Kinerja Program

Annual Report Year 4

Part A – Kinerja Quarterly Report
Part B – Kinerja Papua Expansion Quarterly Report
(October 2013 – September 2014)

11/7/2014
This publication was produced for review by the United States Agency for International Development. It was prepared by RTI International.

Part A – Kinerja Program
Part B – Kinerja Papua Expansion

Annual Report
For the period October 2013 – September 2014

Cooperative Agreement No. AID-497-A-10-00003
September 30, 2010, through February 28, 2015
No-Cost Extension granted until September 30, 2015

Prepared for
USAID/Indonesia
United States Agency for International Development

Prepared by
RTI International[1]
3040 Cornwallis Road
Post Office Box 12194
Research Triangle Park, NC 27709-2194

DISCLAIMER
The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

[1] RTI International is a trade name for Research Triangle Institute.

Kinerja Abbreviations/Terms

Adat	Traditional leaders/traditional law/traditional custom
AIDS	Acquired Immune Deficiency Syndrome
AJI	Alliance of Independent Journalists
AOR	Agreement Officer Representative
APBD	District Government Annual Budget *(Anggaran Pendapatan dan) Belanja Daerah*)
APEKSI	Indonesian Association of Municipal Governments *(Asosiasi Pemerintah Kota Seluruh Indonesia)*
AWP	Annual Work Plan
BAKD	Director General of Regional Financial Administration (*Direktorat Jenderal Bina Keuangan Daerah)*
BaKTI	Eastern Indonesia Knowledge Exchange or BaKTI Foundation *(Yayasan BaKTI)*
Bappeda	Local Government Agency for Regional Development Planning *(Badan Perencanaan Pembangunan Daerah)*
Bappenas	National Development Planning Agency *(Badan Perencanaan dan Pembangunan Nasional)*
BASIC	Better Approaches to Service Provision Through Increased Capacity
BEE	Business-Enabling Environment
BHS	Access to Basic Health Services
BITRA	Indonesia Foundation for Rural Development (*Bina Ketrampilan Pedesaan*)
BKD	District Personnel Board *(Badan Kepegawaian Daerah)*
BKPM	Investment Coordination Board (*Badan Koordinasi Penanaman Modal*)
BOK	Health Operational Grant (*Bantuan Operasional Kesehatan)*
BOS	School Operational Assistance *(Bantuan Operasional Sekolah)*
BOSDA	World Bank term for BOSP
BOSP	Educational Unit Operational Cost Analysis *(Biaya Operasional Satuan Pendidikan)*
BPMD	Regional Investment Board *(Badan Penanaman Modal Daerah)*
BPPKB	District Family Planning and Women Empowerment Body (*Badan Pemberdayaan Perempuan dan Keluarga Berencana)*
Bupati	District Head
CHS	Complaint Handling Survey
COP	Chief of Party
CORDIAL	Center for Indonesian Human Resource Development
CS	Complaint Survey
CSI	Customer Satisfaction Index
CSO	Civil society organization
CSR	Corporate Social Responsibility
DBE1	Decentralized Basic Education
DCOP	Deputy Chief of Party
DEO	District Education Officer
DG	Democratic Governance
DHO	District Health Office

Dinas Kesehatan	health line agency
District	In this report the term District will be used to refer to both regencies (*kabupaten*) and municipalities (*kota*)
DPKAD	District Asset and Finance Management Office (*Dinas Pengeleloaan Keuangan dan Aset Daerah*)
DPRD	Regional Legislative Body at either the provincial, district, or municipality level (*Dewan Perwakilan Rakyat Daerah*)
EBF	Exclusive Breastfeeding
EDS	School Self-Evaluation (*Evaluasi Diri Sekolah*)
EGI	Economic Governance Index
EMIS	Education Management Information System
FGD	Focus Group Discussion
FIK-ORNOP	Nongovernmental Organization Information and Communication Forum Sulsel (*Forum Informasi dan Komunikasi Organisasi Non-Pemerintah Sulawesi Selatan*)
FIPO	Fajar Institute for Pro-Autonomy
FOIA	Freedom of Information Act
FY	Fiscal Year
GERAK	*Gerakan Anti Korupsi, Aceh*
GJI	Governing Justly and Democratically
GOI	Government of Indonesia
HIV	Human immune deficiency virus
HO	Hinder Ordonantie (Nuisance Permit)
HSS	Health Systems Strengthening
Humas	Public Relations (*Hubungan Masyarakat*)
I&EBF	Immediate and Exclusive Breastfeeding
ICLD	International Center for Local Democracy
IDR	Indonesian Rupiah
IKM	Customer Satisfaction Index (*Indeks Kepuasan Masyarakat*)
IMB	Building Permit (*Izin Mendirikan Bangunan*)
IMPACT	Inspiration for Managing People's Action (an IO)
IO	Intermediary Organization
IR	Intermediate Results
ISAI	Institute for the Studies on Free Flow of Information (*Institut Studi Arus Informasi*)
ISO	International Organization for Standardization
Jampersal	Health insurance for maternal safe delivery *(Jaminan Persalinan Universal*)
JPIP	Jawa Pos Institute for Pro-Autonomy
JTV	Jawa Pos Television
Jurnal Celebes	Journalist Network for Environmental Advocacy (*Perkumpulan Jaringan Jurnalis Advokasi Lingkungan*)
Kabupaten	District
Kecamatan	Subdistrict
Kementerian PAN	Ministry for State Administrative Reform (*Kementerian Pendayagunaan Aparatur Negara*)
Kemitraan	Partnership for Governance Reform
KIA	Mother and Child Health (*Kesehatan Ibu dan Anak*)
KIP	Public Access to Information (*Keterbukaan Informasi Publik*)

KM	Knowledge Management
Konsil LSM	Indonesian NGO Council
KOPEL	*Komite Pemantau Legislatif*
Kota	Municipality
KP3M	Service Standards in the Office for Business Licensing and Investment Services (*Kantor Pelayanan Perizinan dan Pelayanan Modal*)
KPPOD	Indonesia Regional Autonomy Watch *(Komite Pemantauan Pelaksanaan Otonomi Daerah)*
KUA	Subdistrict Religious Affairs Office *(Kantor Urusan Agama)*
LAN	State Administration Agency (*Lembaga Administrasi Negara*)
LBA	Local Budget Analysis
LBI	Local Budget Index
LBS	Local Budget Study
LDHE	Local District Health Expert
LEGS	Local Economic Governance Survey
LGHS	Local Governance Health Specialist
LPA	*Lembaga Perlindungan Anak*
LPKIPI	Indonesian Institute for Education Innovation Training and Consulting *(Lembaga Pelatihan dan Konsultan Inovasi Pendidikan Indonesia*
LPKP	Institute for Community Research and Development (*Lembaga Pengkajian Kemasyarakatan dan Pembangunan)*
LPSS	Local Public Service Specialists
M&[I]E	Monitoring and [Impact] Evaluation
M&E	Monitoring and Evaluation
Madanika	Building Peace and Justice *(Membangun Perdamaian dan Keadilan)*
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MenPAN	Ministry for State Administrative Reform *(Kementerian Pendayagunaan Aparatur Negara)*
MOEC	Ministry of Education and Culture
MOF	Ministry of Finance
MOH	Ministry of Health
MOHA	Ministry of Home Affairs
MORA	Ministry of Religious Affairs
MOU	Memorandum of Understanding
MSF	Multi-Stakeholder Forum
MSME	Micro, Small, and Medium Enterprises
MSS	Minimum Service Standards
NGO	Nongovernmental organization
OCA	Organizational Capacity Assessment
OSS	One-Stop Shop (services)
PC	Provincial Coordinator
Pemekaran	Proliferation of regions
PEO	Provincial Education Office
Permendagri	Ministry of Home Affairs Regulation *(Peraturan Menteri Dalam Negeri)*
PKBI	Indonesian Family Planning Association (*Perkumpulan Keluarga Berencana Indonesia)*
PKPA	Center for Child Protection and Research (*Pusat Kajian dan Perlindungan Anak*)

PKPM	*Pusat Kajian Pendidikan dan Masyarakat*
PMC	Project Management Committee
PMP	Performance Management Plan
PMPK	The Center for Health Service Management *(Pusat Manajemen Pelayanan Kesehatan)*
PMTCT	Prevention of Mother-to-Child Transmission
PNC	Postnatal Care
POKJA	Working group
POPI	Provincial OSS Performance Index
Posyandu	Integrated Services Post *(Pos Pelayanan Terpadu*)
PP	Pontianak Post
PPD	Public-private dialogue
PPID	Local Government Public Information Official *(Pejabat Pengelola Informasi Daerah)*
PPLKB	Family Planning Program Controller *(Pengendali Program Lapangan Keluarga Berencana)*
PPMN	Indonesia Association for Media Development (*Perhimpunan Pengembangan Media Nusantara*)
ProRep	USAID Program Representasi (ProRep)
PS	Peer Educators (*Pendidik Sebaya)*
PSA	Public service announcements
PSD	Public service delivery
PSS	Public Service Standards
PTD	Proportional Teacher Distribution
PUM	Directorate General for Administration in the Ministry of Home Affairs
PUPUK	Association for the Advancement of Small Business *(Perkumpulan Untuk Peningkatan Usaha Kecil)* (a TAF partner organization)
Puskesmas	Community Health Center *(Pusat Kesehatan Masyarakat)*
PWS KIA	*Pemantauan Wilayah Setempat Kesehatan Ibu dan Anak*
Qanun	Local regulations in Aceh
RFA	Request for application
RISKESDAS	National Basic Health Survey *(Riset Kesehatan Dasar)*
RKAS	School Development Budget (*Rencana Kerja Anggaran Sekolah*)
RKS	School Development Plan (*Rencana Kerja Sekolah*)
RPJMD	Medium-Term Development Plan *(Rencana Pembangunan Jangka Menengah Daerah)*
RTI	RTI International
SBM	School-Based Management
SD	Elementary School *(Sekolah Dasar)*
SDU	Subdistrict unit
Sekda	Regional Secretary *(Sekretaris Daerah)*
Seknas FITRA	National Secretariat of the Indonesian Forum for Budget Transparency *(Sekretariat Nasional Forum Indonesia untuk Transparansi Anggaran)*
SERASI	Engaging Citizens in Peace
SI	Social Impact, Kinerja Partner Organization
SIAP 2	Strengthening Integrity and Accountability Program 2
SIM-NUPTK	Management Information System for Teachers and Teaching Staff
SITU	Trade Location Permit (*Surat Izin Tempat Usaha*)
SIUP	Trade License (*Surat Izin Usaha Perdagangan*)

SKPD	District Technical Working Unit *(Satuan Kerja Perangkat Daerah)*
SMERU	SMERU Research Institute, Kinerja Partner Organization
SMP	Junior Secondary School *(Sekolah Menengah Pertama)*
SOP	Standard Operating Procedure
SOW	Scope of work
SPP	Public Service Standards *(Standar Pelayanan Publik)*
STTA	Short-Term Technical Advisor
SUM	Scaling Up for Most-at-Risk Populations
SUSENAS	National Socio-Economic Survey *(Survei Sosial Ekonomi Nasional)*
TAF	The Asia Foundation, Kinerja Partner Organization
TB	Tuberculosis
TBA	Traditional Birth Attendants
TDI	Industrial License (*Tanda Daftar Industri*)
TDP	Company registration license (*Tanda Daftar Perusahaan*)
TNA	Training Needs Assessment
TOR(s)	Term(s) of Reference
TOT	Training of Trainers
TP3S	Public Service Development Team for Schools (*Tim Pengembang Pelayanan Publik di Sekolah*)
UGM	Gadjah Mada University, Kinerja Partner Organization *(Universitas Gadjah Mada)*
UGM PMPK	The Center for Health Service Management (*Pusat Manajemen Pelayanan Kesehatan*) of the Gadjah Mada University Faculty of Medicine
UKM	Forum of Regional, Small, and Medium Businesses (*Forum Daerah Usaha Kecil Menengah*/Forda)
UNAIR	Airlangga University in East Java *(Universitas Airlangga)*
UNCEN	Cenderawasih University
UNfGI	University Network for Governance Innovation
UNHAS	Hasanuddin University in South Sulawesi *(Universitas Hasanuddin)*
UNICEF	United Nations Children's Fund
UNPSA	United Nations Public Service Award
UNSYIAH	Syiah Kuala University in Aceh *(Universitas Syiah Kuala)*
UNTAN	Tanjungpura University in West Kalimantan *(Universitas Tanjungpura)*
UP4B	Special Unit on the Acceleration of Development in Papua and West Papua
UPTD	Regional Technical Service Unit *(Unit Pelayanan Teknis Daerah)*
US	United States
USAID	United States Agency for International Development
USG	United States Government
Walikota	Municipality Head/Mayor
WHO	World Health Organization
WRI	Women's Research Institute
YAPIKMA	*Yayasan Pemberdayaan Intensif Kesehatan Masyarakat*
YAS	Prosperous Justice Foundation *(Yayasan Adil Sejahtera)* (a TAF partner organization)
Yayasan BaKTI	Eastern Indonesia Knowledge Exchange or BaKTI Foundation
YIPD	Local Government Innovation Foundation *(Yayasan Inovasi Pemerintahan Daerah)*

YKH	Hometown Foundation *(Yayasan Kampung Halaman)*
YKP	The Women's Health Foundation *(Yayasan Kesehatan Perempuan)* (an IO)

Definitions:

Districts: In this document, the term "districts" refers to both *kabupaten* (districts) and *kota* (municipalities) for purposes of simplicity. The term "target districts" refers to the geographical areas that will receive technical assistance.

HIV/AIDS: Recognizing that there exists a variety of debate and terminology within the public health sector, the term "HIV/AIDS" is used within this document to reflect USAID terminology used in Indonesia.

Table of Contents

Kinerja Abbreviations/Terms ..... **i**

Table of Contents **7**

Executive Summary **9**

Introduction: Improving Service Delivery in Indonesia **13**

Part A: Kinerja Program Annual Report **14**

1. Introduction **15**

2. Incentives and Innovations **16**

2.1 Summary of Progress in Health Governance 16

2.2 Summary of Progress in Education Governance 22

2.3 Summary of Progress in Business-Enabling Environment (BEE) Governance 31

2.4 Summary of Progress in Cross-Cutting Issues 36

3. Replication **43**

3.1 Replication within Kinerja-Supported Districts 43

3.2 Replication to Additional Districts 45

3.3 National-Level Replication Efforts 50

4. Project Management **54**

4.1 Second- and Third-Round Grants 54

4.3 Cost Share 55

5. Summary of Challenges and Next Steps **55**

6. Monitoring and Evaluation **56**

6.1 M&E Activities Summary 56

6.2 Routine Monitoring and Program Support 56

6.3 Measuring Kinerja's Achievements 59

6.4 Lessons Learned and Steps Forward 69

6.5 SMERU: Qualitative Data Collection 70

Annex A-1: Kinerja Packages Based on District Consultations **73**

Annex A-2: Kinerja Performance Monitoring Plan Achievement **74**

Annex A-3: List of Local Regulations Passed in FY 2014 ..... **88**

Aceh 88

East Java 89

West Kalimantan 89

South Sulawesi 90

Annex A-4: Kinerja Grants – FY 2014 93

Part B: Kinerja Papua Quarterly Report 98

1. Introduction 99
1.1 Program Background and Context 99
1.2 Objectives and Results 100

2. Building Relationships with Local Government 100
2.1 Project Management Committee (PMC) 100
2.2 District-level Technical Teams 101

3. Innovations and Incentives 102
3.1 Strengthening Leadership and Management Capacity for Health Service Delivery 102
3.2 MRP/DPRD 108
3.3 Enhancing Citizens' Understanding of their Health Rights 109
3.4 Supporting Demand for Health Services - MSF Engagement 111
3.5 Cross-cutting issues 113

4. Replication 117
4.1 Knowledge Management of Good Practices 117
4.2 Replication within Kinerja Districts 118
4.3 Cooperation with Donors 119
4.4 IO Capacity Development 120

5. Project Management 121
5.1 Grants Management 121
5.2 Cost Share 121

6. Challenges and Next Steps 121

7. Monitoring and Evaluation 121
7.1 M&E Activities: Quarter 4, Fiscal Year 2014 121
7.2 M&E Activities: Fiscal Year 2014 122
7.3 Measuring Kinerja Papua's Achievements 124
7.4 Lessons Learned and Steps Forward 129

Annex B-1: Kinerja Papua Performance Monitoring and Evaluation Plan Achievement 131

Executive Summary

Building on the successes of the previous year, the Kinerja program (together with its Papua component) continued to make great strides not only in improving the delivery of public services in health care, education and business, but more importantly in incorporating key components of good governance to ensure that these achievements are not one-off successes, but the first in a long line of reforms to come.

In FY 2014, Kinerja saw tremendous progress in its health-related work. Service charters were signed in all partner 61 *puskesmas*, including 16 in Papua, demonstrating solid commitments on behalf of service providers to address public complaints. District partners have reduced risks facing pregnant mothers, and for the first time in history, the district of Simeulue celebrated a perfect record of zero maternal deaths for 2013. At a public ceremony, district leadership credited Kinerja assistance for making what seemed like a distant goal a concrete reality. The breastfeeding programs made impressive progress in Makassar and East Java Province and contributed to considerable reduction in distribution of formula milk from public health facilities, supported by multi-stakeholder forum (MSF) monitoring efforts. The reproductive health education program piloted in Bondowoso has been expanded to cover more schools via new student enrollment activities and was introduced in Sambas and successfully adapted for use in Papua as a preventative measure against HIV/AIDS and against gender-based violence. Districts have also expanded partnerships between traditional birth attendants and medically trained midwives, from small pilot programs with limited scope, to district-wide initiatives – providing greater access to pre- and post-natal health services.

Beyond Kinerja's supply-side interventions, the program saw tremendous support for demand-side components in FY 2014. For example, the implementation of public complaint surveys has become a pre-condition for achieving BLUD (financial autonomy) status in the district of Sambas, which selected the health package in Round 1. All six Kinerja pilot *puskesmas*, as well as the seven replication *puskesmas* added in 2013 have achieved BLUD status, which allows community health clinics to retain the revenues they earn from services rendered rather than returning them to the district treasury.

In education, the program continued to make major gains. Luwu Utara managed to become Kinerja's first district to successfully relocate teachers to underserved schools based on the proportional teacher distribution (PTD) package. Based on the technical analysis of Kinerja's IO, the district reassigned 129 teachers to underserved schools, and conducted an evaluation of the operation with the district multi-stakeholder forum (MSF). The district of Barru is on track to follow suit in December, so as to avoid disruptions in classroom activities, with more than 300 teachers slated for reassignment.

Among the districts conducting the BOSP program, Bulukumba has continued to increase funding allocations and ensure they sufficiently address the budgetary shortcomings facing the district's schools. Kota Banda Aceh and Simeulue both passed regulations to address funding gaps facing schools in their respective areas. The new formula adopted by both districts goes beyond the calculation of operational costs per student, and provides weighted distributions for small schools and schools with outstanding academic performance.

Kinerja's long-term investment in building public capacity to conduct oversight and advocacy has led to increased levels of community participation in the management of their education system as well as very tangible improvements. More than 150 partner schools have completed

service charters and technical recommendations. Based on monitoring conducted by MSFs in 103 schools, close to 80 percent of the more than 3,000 service charter pledges had been completed or fulfilled. Kinerja's partner schools, after implementing the SBM program, have harnessed public support to complete extensive renovations of run-down or inadequate facilities; to plant and maintain science gardens; to expand libraries; to create healthy, parent-run cafeterias; and to generally improve the quality of the educational environment. At the micro level, any of these improvements might easily be mistaken as a small and rather routine change; however, when observed in the larger context these improvements not only offer tangible benefits for students, but are symbolic of a greater public concern and involvement in local education.

District partners have also made great strides in promoting a business enabling environment through initiatives to simplify licensing requirements and increase the authority of One-Stop Shops (OSS); to improve OSS business practices, including introducing standard operating procedures, processing times and clearly posted application fees; and improving OSS governance through public feedback and complaint handling mechanisms. As a result of a more positive business climate, districts such as Barru saw improvements in licensing lead to incredible investment growth, increasing from IDR 42 billion in 2010 to IDR 1.4 trillion in 2013. During the last year, Provincial OSS Forums have been strengthened to enhance the capacity of the district-level OSS through thematic and multi-district training/workshops as well as to utilize provincial and district government budgets to directly support interested local governments. East Java has shown especially promising progress.

MSFs grew in maturity via a process of revitalization and institutional strengthening supported by Kinerja. With support from the program, the district MSF in Bener Meriah Aceh successfully lobbied the local legislative council (DPRK) for additional funding to address needs identified in complaint surveys. One member of the DPRK supported the move to the extent that he would not consider any further funding requests *without* MSF support.

The media reported more than ever on issues related to public service delivery in all of Kinerja's areas, from Aceh to Papua. In addition to mainstream media reporters, a total of 198 citizen journalists were active throughout the year under the main Kinerja program, while 70 were active under the Kinerja Papua program. These volunteer writers and photographers have used the training and support from the Kinerja program to produce news products that have been published in a variety of online and social media outlets, and a number of stories have even been picked up by mainstream regional and national media. Through activities such as community film screenings in Papua, Kinerja continues to keep the spotlight on public service delivery issues. In so doing, it helps to create public awareness, increases accountability, and educates the public about their rights to quality services.

Kinerja's work in health and education has also been supported by its technical assistance on planning and budgeting to achieve nationally mandated minimum service standards (MSS). Kinerja has seen encouraging progress in all of its districts, including its four partner districts in Papua, toward more accurate, data-driven planning and budgeting. Through a partnership with CHAI, Kinerja Papua has helped to implement planning and budgeting based on minimum service standards (MSS) at the *puskesmas* level, which has since become a DHO requirement for all *puskesmas* in the district of Jayawijaya. These budgets, which are tied to specific indicators, enable the government and the public to then better monitor outcomes based on allocations.

Incorporating gendered perspectives into its work has remained a priority for Kinerja and Kinerja Papua. In the core program, additional training has helped local partners to integrate the concept of gender equity into programmatic activities, while Kinerja Papua has made significant inroads in addressing gender-based violence in the province, both through its work to support integrated treatment and counseling work, as well as preventative efforts through the adaptation of the adolescent reproductive health education module.

The program has built strong partnerships with the district governments in its treatment and replication areas. These relationships have been crucial for program implementation and have been foundational for the achievement of cost share targets.

Now in its fourth year, Kinerja is at the stage where significant success and lessons are emerging in most of its partner regions. Last year, a revised strategy was accepted by USAID, focusing its replication efforts on the existing districts and extension of interventions to an additional 25 districts (10 for health and education combined, 15 for BEE). The program prioritized replication efforts within treatment districts, so that the inclusion of additional service delivery units could work to reinforce the program's consolidation efforts to improve district technical office capacity and ownership of the program's interventions. Kinerja also focused on replication to additional districts within its partner provinces, where the project had considerable influence and was able to plan activities that directly reinforced its aims and involved local actors. Good practices have been replicated to 314 additional service delivery units, including 296 schools and clinics from Main Kinerja, and 27 *puskesmas* in Kinerja Papua. The program's good practices have been adopted by 35 districts beyond Kinerja's original target areas.

Replication efforts have also shared the program's proven good practices at the national and even international level. Kinerja organized the Symposium on Innovation in Public Service Delivery on June 16–17 in collaboration with KemPAN-RB and a broad range of international development partners. The symposium, which drew over 500 participants from around Indonesia, provided districts the opportunity to showcase their achievements, and discuss how central and provincial governments can ensure sustainability and replication of good practices. After an opening by former Indonesian vice president Boediono, the symposium also addressed efforts for replication of good practices such as competition, financial incentives, national regulations, policies. The provincial government of Aceh was recognized with a national award for its work to promote transparency, and Kinerja's partner districts have been recognized through the Pro Autonomy Awards programs in East Java, South Sulawesi and West Kalimantan. Three Kinerja districts became among the first ever from Indonesia to be selected as finalists for the prestigious United Nations Public Service Award (UNPSA), which recognizes outstanding performance and innovations in public policy.

This progress has not been without significant challenges. In FY 2014, government staff turnover continued to be a persistent challenge. While in principle, routine staff rotations are designed to prevent the emergence of rent-seeking behaviors, in practice, it makes the establishment of programmatic continuity a continual struggle.

The 2014 election cycle both served as a momentous occasion in Indonesia's democratic history and as a significant distraction, and even threat at times, to the project's activities and staff. Electoral violence in Papua stalled events for months, while campaign activities occupied a number of district leaders for a number of weeks.

Although overall progress was positive in the implementation of Kinerja's education packages, a number of challenges were identified that hindered achievement of program goals in education. Procedural delays from local government partners have prevented the passage of key supporting regulations and budget resources needed to proceed with the implementation of the BOSP and PTD packages. MSF involvement in the SBM package continues to show progress, but always has room for further improvement.

The strengthening of MSFs in most regions is a long-term investment. Educating MSFs, helping them to formulate their concerns and needs, and putting them in an oversight role involves a significant amount of effort to foster a change in mindset and requires steady mentoring support.

Replication has been delayed by a focus on consolidation as a result of audit findings, and by the need to follow the annual cycle of budget planning. As a result of these two factors, in many of its replication districts, Kinerja technical assistance has been forced to focus on the implementation of components of each package, rather than the full package.

The newly granted extension of the program in October, allows the program to focus on additional capacity building of IOs, further consolidation of its programming in selected treatment districts and to ensure that replication can sufficiently take root and the benefits of Kinerja's proven good practices can be extended to reach even more lives.

Introduction: Improving Service Delivery in Indonesia

Democratic reforms and decentralization have brought government ever closer to Indonesia's citizens. Government accountability is slowly increasing as democratic reforms allow citizens to directly elect district/municipal heads and local legislatures, and decentralization has allowed local governments a greater opportunity to tailor policy and public services to respond to local needs. Many local governments are rising to public service delivery challenges by creating innovative programs that can serve as examples of excellence for the entire nation.

The United States Agency for International Development's (USAID's) Local Governance Service Improvement (Kinerja) Program works directly with local governments to improve public service delivery by identifying, testing, and replicating innovative interventions to improve measurable performance.

The Kinerja Program was awarded as cooperative agreement No. AID-497-A-10-00003 to RTI International and its consortium of five partners: The Asia Foundation (TAF), Social Impact (SI), SMERU Research Institute, the University of Gadjah Mada (UGM), and the Partnership for Governance Reform (Kemitraan). The period of implementation of this program is September 30, 2010, through February 28, 2015. This program works in the four provinces of Aceh, West Kalimantan, South Sulawesi, and East Java. In each of these provinces, Kinerja works in four districts and one city. In March 2012, USAID awarded RTI with a program extension to include Papua. This extension focuses on Health System Strengthening in the areas of Maternal and Child Health (MCH), tuberculosis (TB), and human immunodeficiency virus/Acquired Immune Deficiency Syndrome (HIV/AIDS).

Kinerja aims to improve the service delivery of local governments in three sectors: education, health, and the business-enabling environment (BEE). To achieve this improvement, the program works with three types of interventions in mind:

1. Incentives—Strengthen the demand side for better services;
2. Innovations—Build on existing innovative practices and support local government to test and adopt promising service delivery approaches; and
3. Replication—Expand successful innovations nationally and support Indonesian intermediary institutions to deliver and disseminate improved services to local government.

Kinerja also studies the level of impact achieved through these interventions. This includes an impact assessment to determine which interventions work, why, and how.

Kinerja seeks to apply good governance practices in public service delivery at the district and community levels. Its programs are aligned with national government priorities that all regions are required to implement and that have widespread applicability with local governments. This program seeks to support and enhance existing local government programs through a limited open menu of key sectorial interventions that form the basis for the incentives, innovations, and replication packages in Kinerja.

Part A: Kinerja Program Annual Report

This section of the overall Kinerja Program and Papua Expansion Quarterly Report – Part A: Kinerja Program Annual Report – includes the progress and achievements for the four original provinces and 20 original districts of the Kinerja program and covers the period from October 2013 – September 2014. As per USAID's request, the Papua Expansion is covered in Part B: Kinerja Papua Quarterly Report, and it includes the province of Papua and the four designated districts within the province. It covers activities carried out under the same reporting period.

1. Introduction

The Kinerja Program was awarded as cooperative agreement No. AID-497-A-10-00003 to RTI International and its consortium of five partners, including The Asia Foundation (TAF), Social Impact (SI), SMERU Research Institute, Gadjah Mada University (UGM), and Partnership for Governance Reform (Kemitraan). The period of implementation of this program is September 30, 2010, through February 28, 2015, with a no-cost extension until September 30, 2015. The program works in the five provinces of Aceh, West Kalimantan, South Sulawesi, East Java, and Papua[2]. In each of these provinces Kinerja works in four districts and one municipality[3]. Kinerja aims to improve the service delivery of local governments in three sectors: education, health, and the business-enabling environment (BEE). To achieve this improvement, it works with three types of interventions in mind:

1. **Incentives –** Strengthen the demand side for better services;
2. **Innovation –** Build on existing innovative practices and support local government to test and adopt promising service delivery approaches; and
3. **Replication –** Expand successful innovations nationally and support Indonesian Intermediary Institutions to deliver and disseminate improved services to local government.

Kinerja also studies the level of impact achieved through these interventions. This includes a rigorous impact assessment to determine which interventions work, why, and how.

[2] The Kinerja Papua Add-On was awarded on March 16, increasing the number of provinces to five and the number of districts to 24.

[3] In this report, districts and cities receiving Kinerja support will be referred to as districts.

2. Incentives and Innovations

2.1 Summary of Progress in Health Governance

Kinerja's health program primarily focuses on improving maternal and child health (MCH) by supporting improvements in local policies related to *puskesmas* (community health clinic) management and their implementation, the promotion of the safe delivery and immediate and exclusive breastfeeding (I&EBF) and the engagement of civil society in providing greater accountability and oversight.

Kinerja's activities are designed to support both local and national priorities in improving service delivery – through standard operating procedures (SOPs), improved information management and innovative partnerships between midwives and traditional birth attendants (TBAs) – while also enhancing the transparency of public finances and ensuring health-care services are responsive to public demands through complaint surveys and service charters.

The Kinerja health program covers a total of 19 districts, with six receiving support round-1 and an additional 13 districts prioritizing health interventions in round-2. A full list of the health districts is available in Annex A-1.

FY 2014 marked an important milestone in the Kinerja program with all 61 partner puskesmas having signed service charters (as expected Sekadau signed service charters during Q2). In Q4 of FY 2014, 55 of these service charters were completed.

Furthermore, the district of Aceh Singkil was selected as a finalist for the prestigious United Nations Public Service Award (UNPSA) for its work to create partnerships between TBAs and midwives. This was the first year that any nominee from Indonesia made it to the final round of the international awards program.

In addition, Puskesmas Sumberasih in Probolinggo won an award for the second best-achieving *puskesmas* in East Java.

In responding to the findings of last year's audit, in FY 2014 Kinerja focused its efforts on ensuring that reforms are sufficiently institutionalized with its partner *puskesmas* and District Health Offices (DHOs).

Over the past 12 months, the health team continued to focus on improving DHOs understanding and knowledge of Kinerja's interventions and the best way to implement them, with a particular emphasis on how to scale up and carry out monitoring and evaluation. With this in mind, Kinerja facilitated numerous training workshops and seminars for DHOs with the aim of increasing their involvement in managing, monitoring and engaging with program components in a way that promotes future sustainability of good governance improvements.

For instance, during the last quarter of FY 2014, a workshop was held in Kota Probolinggo to pass on the results of MSF monitoring, service charters and technical recommendations to DHO and *puskesmas* staff. Also in the last quarter of FY 2014, the DHO in Simeulue devised health monitoring tools with the support of Kinerja's IO PKPA.

Overall in FY 2014, IOs in round-2 districts of Aceh, West Kalimantan and East Java managed activities well, while those in South Sulawesi achieved relatively slower progress, especially in supporting the DHO, due to a lack of IO capacity to engage on technical issues. Targeted advice from Kinerja's technical specialists helped to accelerate activities in selected areas in

South Sulawesi, and the program will continue to address this challenge in the coming quarter. Round-1 health districts (Sambas, Kota Singkawang, Aceh Singkil, Bener Meriah, Kota Banda Aceh and Bondowoso) achieved a number of positive results, including in the expansion of the Kinerja health package to 12 additional service units and the allocation of district government funding to support activities beyond the end of the Kinerja intervention.

2.1.1 Local Policies and Regulations

In addition to the 21 regulations passed in FY 2013, Kinerja successfully facilitated the passage of an additional six regulations in FY 2014 to promote I&EBF and initiatives designed to support safe child delivery. This means that 18 out of 19 partner districts have now passed such regulations. This achievement highlights the crucial role of civil society in districts such as Bengkayang, where unrelenting advocacy pressure from Kinerja IOs and local staff resulted in the signing of a regulation in support of safe delivery, *puskesmas* management and I&EBF.

Clinic plays central role in breastfeeding increase

As part of a broader campaign to increase breastfeeding, Kinerja partner Puskesmas Beji in Tulungagung, East Java backed out of its contract with a formula milk company. As of May 2013, the clinic's staff is no longer permitted to serve as distributors for the product.

The bold decision, taken by the head of the *puskesmas*, brought the community clinic in line with demands from a citizen oversight board and also coincided with a new district regulation that prohibited the distribution of formula milk at public health facilities.

"In truth, I was the one who originally signed the contract, so it only follows that I should be the one to break it…I am providing example to all of my staff – nothing is difficult if we have a strong desire [to change]," said Puskesmas Beji director, as previously quoted by Tulungagung citizen journalist.

The effects have been dramatic. Between May and July, Puskesmas Beji saw the percentage of mothers using exclusive breastfeeding rise from 54.65% to 87.5%.

In addition to prohibiting hand-outs of formula milk, Puskesmas Beji has taken aim at a local belief that babies only cry when they are hungry, and that formula milk is a necessary dietary supplement.

"We provided counseling to pregnant mothers and their families, beginning with their pre-natal checkups, and continuing through delivery and beyond," said a midwife at Puskesmas Beji. "We also developed a class for pregnant mothers in two villages as a pilot, including Sobontoro and Beji as a way to underscore the importance of exclusive breastfeeding."

Local media, including radio stations Perkasa FM, LIUR FM and Kembang Sore FM, have covered the story, and in doing so have also helped to raise awareness of the importance of breastfeeding and to draw attention to positive policy decisions.

In keeping with the program's expectations, the round-2 district of Aceh Tenggara also passed its regulation in FY 2014 to strengthen support for safe delivery and breastfeeding initiatives. On the other hand, Kota Banda Aceh elected not to pursue a new regulation as it already has its own local Islamic law, Qanun KIBBLA, which provides sufficient coverage for initiatives to promote both issues.

Although conclusive data is difficult to come by, partners in the field have pointed to these regulations, their wide distribution and public discussion as well as pressure from MSFs, as the cause for significant reduction in the distribution of formula milk at public health facilities and an increase in breastfeeding rates among new mothers.

2.1.2 Puskesmas Management

During the past 12 months, Kinerja continued to strengthen the role of DHO in its partner districts to take a more active role in the management oversight and evaluation of program activities. This strategy is aimed at strengthening local actors' abilities to continue the program after the conclusion of direct support. Kinerja worked closely with its IOs and *puskesmas* staff to encourage them to include DHO and Bappeda in *puskesmas* visits to ensure that district officials understand the reality of MCH at the *puskesmas* level, and to facilitate better

relationships with front-line staff. In Luwu and Luwu Utara, DHO and Bappeda are planning to conduct regular *puskesmas* visits after realizing the benefits of such direct oversight.

During FY 2014, Kinerja also supported a number of activities that integrated DHO representatives as key players and drivers of future developments. For example, a training workshop was held in Kota Makassar on June 16-17 with DHO officials and the heads of 23 *puskesmas* to develop service-unit level strategic planning skills based on minimum service standards, Millennium Development Goals and DHO priority programs. Participants felt that the training was extremely helpful, and are using the skills they gained to work on annual budgets and work plans for 2015.

Clinic treats long lines, delays with dose of technology

Like many community health clinics that serve as the backbone of the Indonesian health-care system, Puskesmas Sumberasih is charged with serving the full range of its community's needs – from simple emergency services, to basic health check-ups, dentistry and obstetric services. In tackling this broad challenge, however, it has brought to bear the twin tools of good governance and effective data management.

With Kinerja support, a group of community, traditional and religious leaders gathered together to form a citizen oversight board at Puskesmas Sumberasih in November 2012, revitalizing the previous group that had been formed in the past. As one of their first activities, this multi-stakeholder forum implemented a public complaint survey among the clinic's patients involving some 100 respondents. The results were then analyzed in consultation with the clinic staff, and a service charter, outlining steps to address these complaints, was signed in December 2012.

"From the complaint survey, we learned that many of our patients were unsatisfied with the long waiting times. Although we had been using the electronic patient database *SIMPUSTRONIK* since 2007, we added fingerprint recognition to our patient intake process as a result of public complaints," said *puskesmas* director.

This has helped to reduce check-in times from 3 minutes to mere seconds, even if a patient has forgotten their ID card at home. All they have to do is scan their finger, and their recent medical history is automatically called up in the database. Although this seems like a small change, it is multiplied by nearly 100 patients that we serve every day, and so the efficiency really adds up. It also eases integration with the national universal health insurance program, which kicked into effect on Jan. 1.

"We're a customer-oriented service, and from public surveys we can see where we need to improve, including response time," the director said, noting the many complaint boxes positioned throughout the clinic.

Based on the integration of public participation and innovative reforms, the district health office (DHO) plans to support the further expansion of the Kinerja model in Probolinggo and beyond.

"We plan to replicate the Kinerja program to an additional 10 *puskesmas* this year, so that this kind of needs-based innovation in public service can reach more of our community," said the head of the DHO.

In addition, due to the frequent turnover of staff (90 percent turnover of senior DHO personnel in Bulukumba in the last 12 months) refresher training was conducted to get the new staff up to speed on what constitutes good governance in *puskesmas* management and oversight components. One such workshop attended by DHO, the members of Bappeda and MSF, as well as the heads and staff of all 28 *puskesmas* in the district was held in Tulungagung, East Java, on Sept. 11-12. The workshop encouraged active participation through practical activities on how to conduct monitoring interviews with *puskesmas* patients, how to comprehensively analyze maternal mortality data, and how to ensure monitoring and evaluation recommendations are taken up by the heads of DHO.

Up to date, 54 out of the 61 partner *puskesmas* have drafted SOPs on patient services, ante-natal care, safe delivery, post-natal care, neonatal care and/or immediate breastfeeding. Kinerja also continued to support SOPs to improve the delivery of health services, and its partner clinics in Bulukumba, Bengkayang, Probolinggo, Makassar, Tulungagung and Sambas are now using "control cards" to monitor the implementation of SOPs developed in recent quarters. In addition, the last quarter of FY 2014 saw two partner *puskesmas* in Melawi implement the "control card" system. While the third *puskesmas* has been slower in implementing Kinerja's

program, a new *puskesmas* head has been receptive to the program and has already introduced time standards and patient flowcharts. Significantly, Kinerja has involved DHO representatives in a number of these activities to consolidate the program and the role of district-level actors to carry it forward following the end of Kinerja support.

Kinerja supported a workshop in Puskesmas Lawe Alas, Aceh Tenggara on May 2, resulting in the commitment from the clinic and village midwives to apply an ante-natal care SOP and a patient registration card system. Similarly, the project facilitated a workshop to develop the ante-natal care SOP in Simeulue on May 7. As a result, a new SOP on ante-natal care will be developed at the DHO level and applied to all *puskesmas* in the district. It is expected that the SOP will be implemented in the first quarter of 2015.

To date, all 61 partner *puskesmas* in the Kinerja program have signed service charters to address issues identified in public complaint surveys. Nine of these charters were signed in FY 2014. This marked an important milestone for the Kinerja program, especially considering the relative novelty of adopting public input as a primary driver of public policy in the Indonesian context. In addition, in FY 2014 partner *puskesmas* submitted 26 technical recommendations to DHO authorities in order to address issues beyond clinics' immediate control. A cumulative total of 54 such recommendations have been submitted since the start of the Kinerja program. Finally, 48 *puskesmas* implemented new SOPs in FY 2014, with three SOPs signed in Simeulue, two signed in Sambas and one in Kota Makassar in Q4.

In an interesting development, the implementation of public complaint surveys has become a pre-condition for achieving BLUD (financial autonomy) status in the district of Sambas, which selected the health package in round 1. All six Kinerja pilot puskesmas added in 2013 have achieved this special status, which allows community health clinics to retain the revenues they earn from services rendered for use to purchase laboratory materials, medical supplies, pay for basic facility maintenance and even hire additional personnel on contract basis.

A major breakthrough occurred with the head of the DHO in Kota Singkawang when an agreement was reached to repeat the complaint surveys at Kinerja's three partner *puskesmas*¸ and to expand the activity to the other two community clinics in the city. The DHO head has been resistant to complaint surveys in the past, feeling that they are too broad and that the public lacks the understanding of the legal obligations of the clinics they are evaluating. However, Kinerja was finally able to get the DHO to see the benefit the surveys offer, based on evidence from program-supported *puskesmas*. Kinerja will work with the DHO to establish a detailed plan for the conduct of the second round of complaint surveys.

2.1.3 Promotion of Safe Delivery and I&EBF

Kinerja's efforts to support health promotion activities during the year aimed to raise public awareness of their rights to health, particularly those related to MCH, including safe delivery and I&EBF. By using a broad and flexible approach, Kinerja has been able to capitalize on opportunities for community engagement as they arise.

The round 2-districts of Luwu, Jember and Luwu Utara have made impressive improvements in their delivery procedures thanks to Kinerja assistance. In Luwu, midwives returned to work at their usual *puskesmas* assignments after having completed a four-month professional development program at the local hospital. Armed with new skills, the midwives are now better equipped to handle complications during childbirth and provide safer services for both mother

and child. This internship program emerged as a result of discussions between Kinerja staff and the DHO on ways to reduce Luwu's high maternal mortality rate.

Since the implementation of a similar partnership at Puskesmas Sukamaju in Luwu Utara, South Sulawesi, the number of births assisted exclusively by TBAs, without a medical professional, has fallen from 39 in 2011 to just two thus far in 2014.

In addition, through Kinerja's increased maternal health promotion activities and clearer information displayed at *puskesmas* regarding pregnant women's healthcare rights, almost all partner *puskesmas* witnessed an increase in pregnancy checkups. For instance, in Puskesmas Batua, in Makassar, South Sulawesi, 1283 women had the recommended four pregnancy checkups in 2013, an increase of over 100 from 1,182 in 2012. While data for FY 2014 is not yet available, this positive trend is expected to continue.

Simeulue stamps out maternal mortality

Amid discouraging news this year that Indonesia may have actually lost ground in its pursuit of the Millennium Development Goals related to maternal mortality, the small island district of Simeulue in the province of Aceh is proving that success is possible when the government and civil society come together.

Starting in 2012, the District Health Office (DHO) of Simeulue was selected to take part in a program to improve the governance of public service delivery, provided by the U.S. Agency for International Development (USAID) and implemented by RTI International. This program, known as Kinerja, leveraged additional technical assistance in order to help the DHO achieve its goals in improving basic health care for women and children.

A key area of cooperation supported under the program was to forge a partnership between traditional birth attendants and medically trained midwives, in order to support safer delivery practices. As a result, the district was able to successfully reduce maternal mortality from seven deaths in 2012 to zero in 2013.

Regarding the achievement, the Simeulue DHO director said, "This is the first time in history this has ever occurred in Simeulue, and today we can smile about our achievement. It is truly extraordinary."

At an official awards ceremony, held in early December 2013, the director also credited Forum Bersama Peduli Kesehatan Simeulue, which was established with Kinerja support as a citizen oversight body to help improve health-care delivery, for its crucial support in helping the government to achieve its goals.

"Simeulue currently remains ranked 15th in terms of districts in Aceh facing problems with health, which means that continued progress requires hard work from all stakeholders. We will continue to maximize synergy and partnerships, because health problems are not just the concern of health professionals alone. The role of the public, including support from USAID Kinerja and its partner PKPA in 2013-2014 significantly helped to achieve this goal."

As a token of his gratitude, the district head of Simeulue recently gave a certificate of appreciation to USAID Kinerja chief of party in recognition of the role the program had played in improving maternal and child health.

Since beginning to work with Kinerja, many *puskesmas* have also become more aware of the importance of interventions such as I&EBF. For instance, Puskesmas Sungai Raya Kepulauan in Bengkayang, West Kalimantan, assisted twice as many women in 2013 as in 2012 to immediately breastfeed their babies after birth (208 in 2012 and 451 in 2013). Data from January until September 2014 looks similarly promising, but final data will not be available until December 2014.

In Luwu Utara, the deputy district head officiated the launching ceremony of dedicated breastfeeding area in the DHO as showcase/demo facility for other government offices and community health clinics to follow in the months ahead. The deputy district head has proven to be a strong supporter of the Kinerja program, and as a female politician, has provided a positive role model for others seeking to promote change in the district**.** Overall, in the treatment districts, 38 *puskesmas* have now implemented TBA-midwife partnerships and 45 *puskesmas* have improved or developed their pregnancy information systems, mostly in the

form of the 'delivery pocket' system. In addition, 45 *puskesmas* have now conducted activities to promote breastfeeding to the community.

2.1.4 Adolescent Reproductive Health Education and the Prevention of Underage Marriage

Although Kinerja's pilot program for the promotion of reproductive health and the prevention of underage marriage in the East Java district of Bondowoso concluded around a year ago, local stakeholders remain committed to the program's objectives and continue to conduct outreach activities. Reproductive health training has now been included in new student enrollment activities and sessions were presented to all incoming junior high school students across the district in mid July.

In addition, FY 2014 marked the first time teenagers had been purposely involved in a government adolescent reproductive health education program in Bondowoso. A group of peer educators called the 'Blue Sky Community' held biweekly meetings at the town square and conducted various outreach activities, mainly through the arts. Having initially piloted the peer-educator program in four sub-districts, it has now been replicated in 25 community health center areas and the number of peer educators has risen from 24 to 279. For its outstanding progress, the district of Bondowoso has been nominated for the 2015 UNPSA award.

2.1.5 Multi-Stakeholder Forums (MSFs)

Efforts to strengthen MSFs as independent citizen oversight bodies for the improvement of public services primarily focused on encouraging MSF participation in *puskesmas* activities, and increasing their capacity to carry out monitoring and evaluation activities.

IOs and district staff worked hard to persuade the heads of *puskesmas* about the benefits of including the local MSF in their work. This resulted in some important gains in a number of districts, including Sekadau, West Kalimantan, where the local MSF is now involved in the monthly management meeting of each *puskesmas*.

In FY 2014, one health-related MSF was developed at the district level and six at the sub-district level. In addition, Kinerja IOs continued to support MSF in their monitoring of service charters. Fifty-eight MSFs completed monitoring at the *puskesmas* level, and found that 81.91 percent of the 4,279 pledges included in service charters had been fulfilled.

During FY 2014, Kinerja facilitated trainings for MSFs at both the district and service delivery unit level in the districts of Aceh Singkil, Bondowoso, Jember, Kota Makassar, Probolinggo and Sekadau. New monitoring tools were distributed to aid in the documentation of service charter and technical recommendation fulfillment. Trainings also helped MSFs to improve coordination between district and service delivery unit levels and to formulate advocacy plans to push for reform where supply-side efforts have slowed.

Furthermore, as part of Kinerja's assistance to help the Jember health office to meet minimum service standards (MSS), the project facilitated a monitoring and evaluation workshop for the office's staff and MSF members in Jember on April 23-24. This two-day workshop, which was attended by 30 people, resulted in important evaluation instruments that can be used by both the government and the public.

.

Complaint Surveys

Following the conclusion of complaint surveys in the previous quarter, partner *puskesmas* in Sekadau signed service charters as expected during the January – March period. The achievement marks an important milestone in the Kinerja program with all 61 partner *puskesmas* having signed service charters. In Q4 of FY 2014, 55 of these service charters were completed.

In addition, there were 56 Kinerja-supported feedback mechanisms - such as complaint boxes, SMS gateways and SOPs – regarding the handling of complaints in Kinerja-supported *puskesmas* in FY 2014, with documentation for 15 of those submitted in Q4.

Complaint surveys were also picked up by other actors. During this reporting period, Kinerja supported Banyuwangi to replicate complaint surveys in *puskesmas* by providing training to the staff. During the two-day training, the participants learnt about questionnaire writing, data collection and analysis, and service charter and technical recommendation writing

Next Year

In FY 2015, the Kinerja health team will continue to work with provincial level governments – such as the Bureau of International Cooperation and technical team in East Java, the Health Department in West Kalimantan, as well as technical facilitators in Aceh – to encourage the replication and wider dissemination of Kinerja's good practices throughout the program's partner provinces. Kinerja will continue providing trainings and workshops, and disseminating information on good practices.

Kinerja's efforts in Q1 of FY 2015 will focus on encouraging incorporation of health interventions into budgetary allocations, the goal being improving and creating further partnerships between IOs and local governments. The planned Gap Evaluation meetings will bring together IOs, government partners, and MSFs to analyze gaps that still exist in program implementation and to agree on how to fill them.

In addition, Kinerja's efforts will continue to focus on the further consolidation of its *puskesmas* management package, and additional training of its MSFs to produce verifiable monitoring reports on the fulfillment of service charters and technical recommendations. Where service charters and technical recommendations remain unfulfilled, MSFs will be coached on the design and implementation of advocacy campaigns to achieve public service reforms.

2.2 Summary of Progress in Education Governance

Kinerja's education governance program consists of three packages: Educational unit cost analysis (*biaya operasional satuan pendidikan* - BOSP), proportional teacher distribution (PTD), and school-based management (SBM).

In round 1, Kinerja provided assistance to a total of 11 districts: BOSP (2), PTD (3), and SBM (6). In round 2, Kinerja provided the same assistance in a total of additional seven districts: BOSP (1), PTD (3), and SBM (3). A list of the interventions chosen by the districts is available in Annex A-1.

In FY 2014, Kinerja assisted round-1 and round-2 districts to integrate BOSP, PTD and SBM in planning, budgeting and program implementation. Overall progress of district-level education programs in FY 2014 remained positive, with the successful completion of BOSP analysis and revised budget allocation proposals, the analysis of imbalances in teacher

allocations and the redistribution of teachers, and the implementation of complaint surveys, service charters, financial transparency and improved planning and budgeting in schools.

Due to the strong commitment of the district head and other decision-makers, the progress made by two round-1 districts of Luwu Utara and Barru has remained a point of pride for the program. Cumulatively, the two districts issued executive decisions to reassign 491 teachers at primary school and secondary school level during FY 2014. While teachers have already been reassigned to new schools in Luwu Utara, and an evaluation of the program has been conducted by the district MSF, district officials in Barru have delayed relocations to avoid disruptions to classroom activities. Officials from both districts have expressed their gratitude for the achievements made possible through cooperation with the Kinerja program.

Furthermore, the district of Luwu Utara was selected as a finalist for the prestigious United Nations Public Service Award (UNPSA) for its work in addressing teaching staff imbalances through the Kinerja PTD program.

Within the school-based management program, the overall fulfillment of service charters was impressive considering the novelty of the approach in many target districts. In FY 2014, an average of 81% of promises made in school service charters were implemented.

In response to the MTE and RIG audit, Kinerja continued to strengthen the oversight and management roles of the District Education Offices (DEO). For round-1 districts, this continued to be done through the targeted support of short-term consultants (STTA). Following In line with the extension of the grants of IOs in three round-2 districts, made in the last quarter of FY 2013, Kinerja made follow-on-grants for IOs working in additional five round-2 districts to see the implementation of education packages through to a point of considerable consolidation and district implementation.

2.2.1 Educational Unit Operational Cost Analysis (Biaya Operasional Satuan Pendidikan – BOSP)

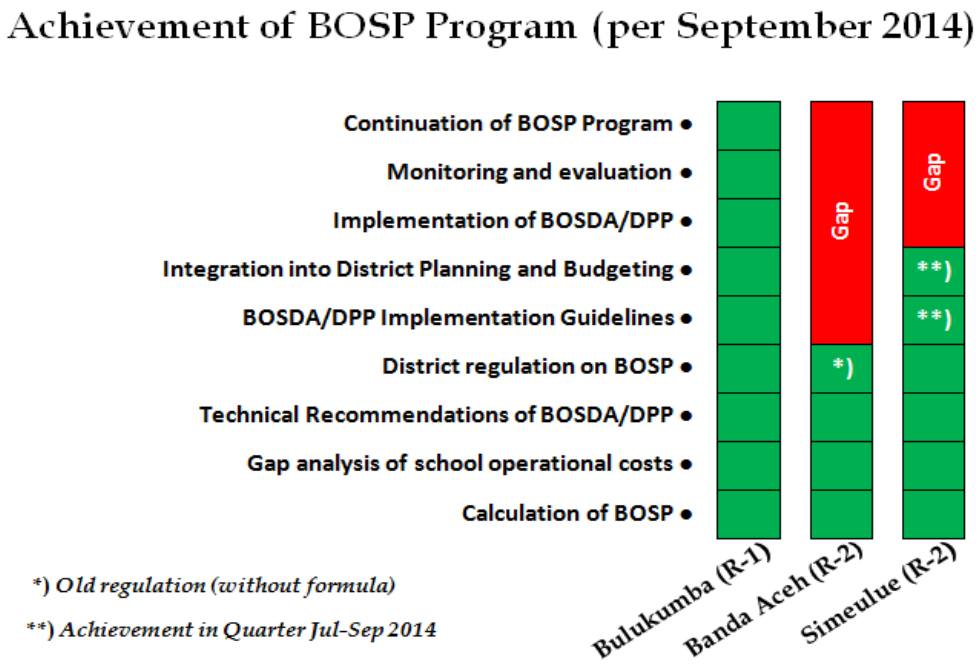
Kinerja worked with three partner districts to calculate the financial gaps between annual central government funding and the operational expenditures required to meet nationally mandated minimum service standards (MSS) through a package known as BOSP. Recommendations to address any financial shortages discovered as a result of careful analysis were made jointly by the District Technical Working Unit, the Revenue and Finance Offices, Bappeda and related community stakeholders via the multi-stakeholder forum (MSF) to offer alternatives from the district or provincial budgets.

Within this component, the district of Bulukumba has consistently stood out for its commitment to addressing funding gaps facing its schools. Even before the Kinerja intervention got underway, the district administration of Bulukumba allocated funds to meet the financial gap, starting in 2012. With Kinerja's assistance, this willingness to address key problems in education has been matched with research and the power of data-driven decision making to increase funding allocations and ensure they sufficiently address the budgetary shortcomings facing the district's schools. During the FY 2014, the DEO allocated IDR 23.2 billion for primary and junior secondary schools, an increase from previous year's IDR 14 billion, and in Q4, the DEO stepped up its efforts to monitoring school fund use. Unfortunately end of Q4, a heavy transfer of staff took place in the DEO in Bulukumba, and many of the key players and champions of the BOSP program were transferred. Kinerja now is discussing with the MSF and the DEO on how to consolidate achievements made.

In addition to the success of Bulukumba in implementing the BOSP program, Kinerja and its IO GERAK continued to facilitate the application of BOSP in Kota Banda Aceh and Simeulue. Kinerja worked with the respective DEOs and other stakeholders to calculate costs for partner schools in the districts, and the two districts have now issued regulations, and Simeulue has issued technical guidelines with participation of MSF to ensure that BOSP is implemented. It should be noted that the increased number of stakeholders involved has improved governance, but has perhaps slowed progress as particular variables, such as school size and student poverty rates are considered for inclusion in the disbursement formula. However, once decisions on the formula have been made, Kinerja's support has ensured that mechanisms are already in place to ensure continued good governance of these funds, including public oversight of funding distribution and its use, as well as the legal obligation for schools to publish annual planning and budgeting documents.

Kota Banda Aceh has been slower in its implementation of the BOSP program than the districts of Bulukumba and Simeulue, as district officials have delayed signing needed regulations in order to include the results of ongoing unit cost calculations associated with senior vocational schools. Siginificantly, Kota Banda Aceh's officials want to apply BOSP to all of the district's schools, not just elementary and junior high schools. Although senior vocational schools are beyond the mandate of the Kinerja program, it is encouraging to see the DEO use the opportunity to make a larger impact for its schools while it has expert technical support available. Kinerja will continue its intensive formal and informal communication and advocacy with the Kota Banda Aceh administration to accelerate its efforts to implement the BOSP program in all of the district's schools.

In order to ensure that the districts fully implement the program – by allocating funds to schools and meeting the financial gap – Kinerja will continue providing support to Kota Banda Aceh and Simeulue. To do this, Kinerja will extend the current grant for IO Gerak in Kota Banda Aceh and Simeulue to ensure intensive advocacy with the local governments. On the technical side, the focus of support in Kota Banda Aceh will be on establishing implementation guidelines and action plans, whereas in Simeulue the focus will be on monitoring the implementation of fund allocation to schools. On the civil society side, priority will be placed on working with district-level MSFs to lobby for the closing of the funding gap.



2.2.2 Proportional Teacher Distribution (PTD)

Through the PTD package, Kinerja assists DEOs to review and analyze relevant district education data in order to address potential imbalances in the distribution of teachers. Kinerja aims to create an environment in which the DEO collaborates with relevant stakeholders in administration through the MSF to implement incentive strategies to encourage teachers to work in remote or otherwise underserved areas.

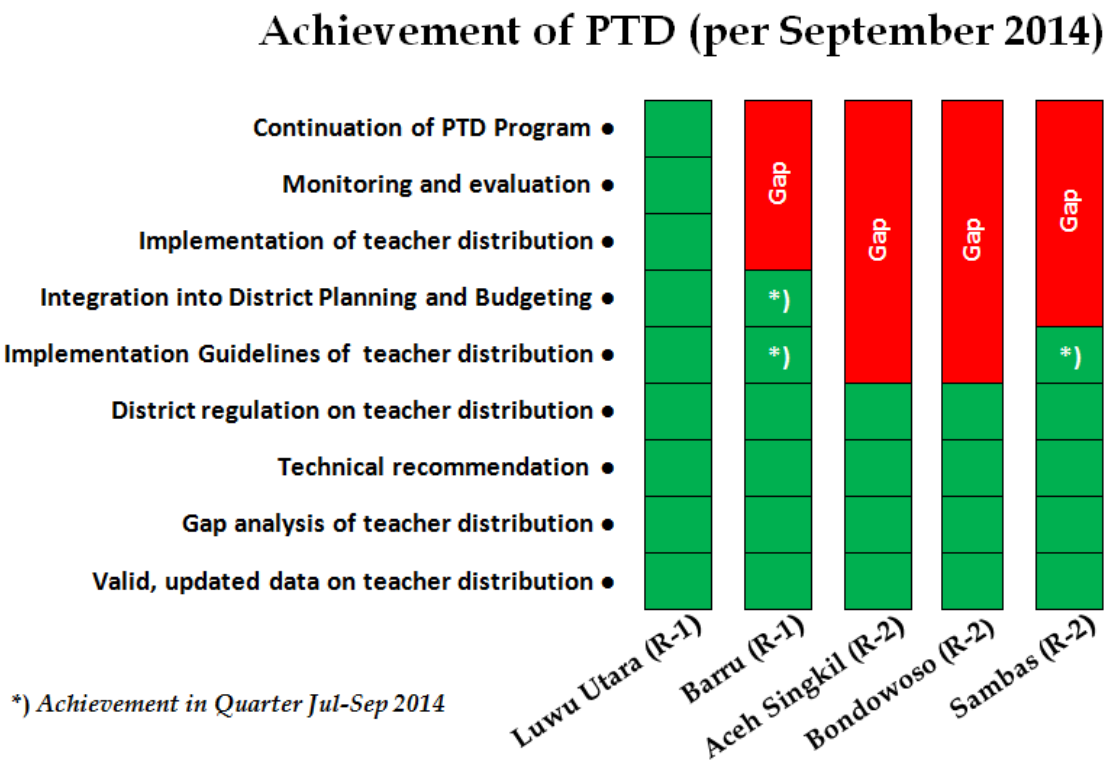
Since Kinerja began, PTD has been supported in a total of six districts: Luwu Utara, Luwu, and Barru in FY 2012; and Aceh Singkil, Bondowoso and Sambas in FY 2013. In FY 2014, Kinerja continued to provide assistance in all the districts except Luwu, where support was discontinued due to a lack of local government commitment.

In response to MTE findings, Kinerja provided an STTA for the round-1 districts of Luwu Utara and Barru as a part of its consolidation measure. The consultant continued the work of IOs whose grants ended at the end of 2012, and focused on the development of PTD monitoring and evaluation tools for primary schools in Luwu Utara.

Due to the strong commitment of the district head and other decision makers, the round-1 districts of Luwu Utara and Barru have made impressive progress. A policy framework was developed and a regulation was issued in both districts with high levels of participation from civil society. Luwu Utara reassigned 128 primary school teachers in the first quarter of FY 2014. Following the same approach, Luwu Utara extended the program to secondary schools, and issued an executive decision in the same quarter to transfer 37 teachers. The deputy district head of Luwu Utara expressed her deep gratitude to the Kinerja program for its support and cooperation in improving the quality of education services. She has appeared in various promotional events, including on national television, alongsiderepresentatives of the Ministry for Bureaucratic and Administrative Reform (KemPAN-RB), to speak about the PTD program in her district. The Luwu Utara PTD story has also been covered by KemPAN-RB's magazine and in several print media.

Similarly, Barru has issued an executive decision to transfer 326 teachers ranging from elementary to senior high schools. A number of small issues pushed plans to relocate teachers beyond the summer holidays in July, so the move has been postponed until the next holiday break in December to minimize disruptions to classroom learning.

Bondowoso and Sambas completed the validation of teacher data and signed implementing regulations in FY 2014, while Aceh Singkil had issued a policy last year. However, Aceh Singkil and Bondowoso have yet to sign implementation guidelines that have been drafted together with MSF through program support. Meanwhile, despite the delays in signing the regulation, Sambas formalized its implementation guidelines in September 2014, and is currently preparing the list of teachers to be reassigned ahead of the move scheduled for December 2014. As a result, Kinerja has extended the grants of its IOs Daun in Aceh Singkil, and LPKIPI in Bondowoso and Sambas until December 2014.



2.2.3 School-Based Management (SBM)

Kinerja's SBM package supports participative, transparent, and accountable processes in school governance. It includes (1) the introduction of education service standards; (2) a community complaint index and school self-evaluation; (3) the participatory preparation of school plans and budgets involving school principals, teachers, school committees and community leaders; (4) the transparent and accountable application of these school plans and budgets; (5) the strengthening of the school committee to oversee the implementation of the school plans; and (6) the strengthening of the school committees to conduct advocacy where service charter implementation is lacking.

During FY 2014, Kinerja continued to provide support to five partner districts that implemented SBM in round-1 (Kota Probolinggo, Jember, Bengkayang, Sekadau, and Melawi) through STTAs and three round-2 partner districts (Bener Meriah, Kota Singkawang, and

Barru) through IOs. This was made possible by the continuation of Kinerja support through STTAs and additional grants.

This year, 100 percent of Kinerja's Round-1 districts completed complaint surveys and signed service charters. As a follow on, 94 of 100 round-1 schools submitted a set of recommendations to the DEO to obtain additional financial and political support. In addition, 93 schools developed their budget plans using public feedback and 82 of them integrated survey results into their plans and budgets. In Sekadau, the DEO took steps to ensure that schools have institutionalized their commitment to making improvements by passing a regulation in Q4 of FY 2014 requiring each school to implement MSS during that quarter.

Progress in Round-2 schools proceeded at various paces depending on variations in local capacity and commitment. In Bener Meriah, Kota Singkawang and Barru, all SBM-supported schools have conducted complaint surveys and 79.38 percent (45 of 60 schools) integrated the results of the complaint survey into their planning documents, based on minimum service standards (MSS) in education. Furthermore, 97.5 percent of schools signed service charters and 95.38 percent submitted technical recommendations to their respective DEO. In Bener Meriah, where resource limitations proved to be a significant factor, community representatives, as members of the multi-stakeholder forum (MSF), took a lead role in an advocacy campaign that succeeded in persuading the local legislative council (DPRK) for additional funding, based on needs identified in complaint surveys. As a result, the district government has allocated IDR 8 billion to address issues such as insufficient classrooms, toilet facilities, and materials such as desks, chairs and books. Kinerja has helped Bener Meriah to apply for the UNPSA Award 2015.

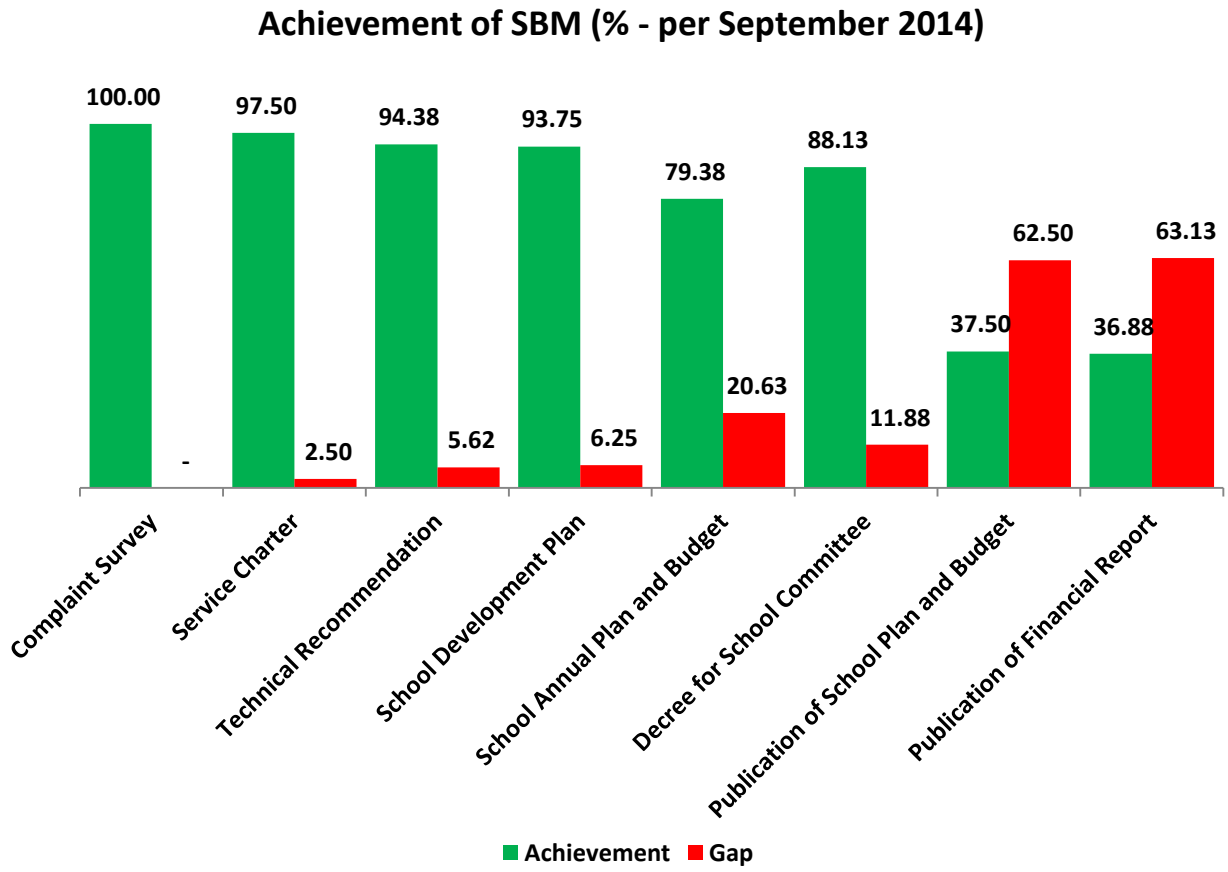
The SBM package increased the awareness and understanding of school committee members about issues related to school budgets and the process used to develop annual plans and budgets. A total of 150 out of 160 (93.75 percent) Kinerja-supported schools developed mid-term School Work Plans *(Rencana Kerja Sekolah)* based on data from the School Self-Evaluation *(Evaluasi Diri Sekolah)* and complaint survey, including 93 schools from round-1 and 57 schools from round-2.

Kinerja's approach to SBM has had an impact on transparency and accountability. In FY 2014, a total of 127 of 160 (79.38 percent) partner schools have prepared annual budgets, 60 (37.5 percent) of which have published an updated annual budget in order to increase transparency and accountability. As this number is rather low, Kinerja will continue to work through its local IOs to optimize the roles of school committees and district MSFs to provide technical assistance to schools, in particular in relation to annual work plans and fiscal transparency.

Some schools have faced challenges in continuing SBM activities due to the high turnover of government employees. Some IOs and STTAs have had to start from the beginning by introducing the project to new staff. For example, Bengkayang and Melawi were not able to complete a regulation on SBM replication by the end of FY 2014 – as had been targeted – due to DEO staff turnover. To address this challenge, Kinerja is planning to strengthen the capacity of the school committee and district-level MSF to continue their advocacy after the project is phased out.

In addition, Kinerja's 60 partner schools from round-1 (Bengkayang, Sekadau, Melawi) and 60 partner schools form round-2 (Bener Meriah, Barru and Singkawang) received training on

the World Bank's Tool for Reporting and Information Management by Schools (TRIMS) software to assist with the development of annual plans and measuring their MSS achievements. The outcome has been impressive. Acknowledging the benefits TRIMS offered in promoting accountability and transparency of educational data and assisting schools develop their work plans, the district of Bener Meriah rolled out TRIMS training to 101 schools and Kota Singkawang replicated it to 145 schools.



2.2.4 Multi-Stakeholder Forums (MSFs)

In providing technical assistance to its partner districts, Kinerja encouraged the creation of good governance by supporting a balance of roles and functions between service providers and service users. To that end, Kinerja worked to develop and further strengthen education MSFs in round-1 and round-2 districts through IOs at the district level and through STTAs at the school level.

In FY 2014, two district-level education-related MSFs were revitalized with Kinerja support, including one in Kota Singkawang in March and one in Jember in April. Activities included refresher training on the groups' roles and functions in the oversight of public services. A number of these activities also involved democratic elections for MSF leadership positions, which help to insure internal governance mechanisms are institutionalized. In addition, 17 school committees were formed or strengthened.

Kinerja's long-term investment in building public capacity to conduct oversight and advocacy has led to increased levels of community participation in the management of their education system as well as very tangible improvements. Kinerja's partner schools, after implementing

the SBM program, have harnessed public support to complete extensive renovations of run-down or inadequate facilities; to plant and maintain science gardens; to expand libraries; to create healthy, parent-run cafeterias; and to generally improve the quality of the educational environment. At the micro level, any of these improvements might easily be mistaken as a small and rather routine change; however, when observed in the larger context these improvements not only offer tangible benefits for students, but are symbolic of a greater public concern and involvement in local education.

This year, MSFs, partner schools and local Kinerja staff in Bener Meriah successfully collaborated to lobby the local legislative council (DPRK) for additional funding to address needs identified through the SBM package, including facility upgrades, ongoing complaint-handling mechanisms and educational supplies for schools. As a result, the district government allocated IDR 100-150 million per school in its 2014 budget to support their ongoing efforts to improve governance, transparency and public participation in education.

In addition, education-related MSF in Luwu Utara conducted an evaluation of the PTD program in conjunction with local governments. The results were then submitted to the DEO, which has elected to continue its PTD program for both junior and secondary school teachers.

Beyond advocacy for improvements, Kinerja continued to support the revitalization of MSFs from round-1 and round-2 districts through refresher trainings on the groups' capacity to carry out monitoring and evaluation activities. These training sessions also offered an opportunity to enhance linkages to DEO officials and to further build the groups' skills in that area. Kinerja facilitated monitoring and evaluation training in Probolinggo and Jember on April 7 and April 16, respectively. The training helped prepare the forum members to evaluate the fulfillment of service charters and technical recommendations using agreed-upon tools. Similar training was provided in Kota Makassar on April 17-19, in Bener Meriah on April 15 and in Sambas on May 6. In addition, Kinerja supported refresher training on complaint surveys and the role of schools committees for MSF members in Jember on May 2.

Complaint Surveys

Following the completion of complaint surveys by all partner schools in FY 2013, a total of 156 service charters have been signed to date to address complaint survey findings, with 100 of those coming from round-1 districts and 56 coming from round-2 districts. Furthermore, technical recommendations were signed by 94 round-1 schools and 57 round-2 schools in FY 2014 in order to raise issues with their respective DEOs and district governments that were identified in the complaint surveys, yet were beyond schools' budgetary or administrative power to control.

School enhances participation, accountability in school funding

One of the biggest challenges for schools in Indonesia as they strive to meet national service standards lies in the availability of adequate resources. Although the national government provides some funds to support the schools' daily operation, the budget is often inadequate and a lack of public trust often limits schools' abilities to raise additional funds from parents and community donations.

However, one school in Melawi, West Kalimantan has demonstrated that increased transparency and accountability opens doors for new funding opportunities from the community and the private sector.

Starting in 2011, SMPN 1 Belimbing conducted an evaluation of its ability to meet nationally mandated service standards, and identified critical areas in need of further attention, such as teacher and student discipline and financial management under Kinerja's school-based management component.

To address these needs, Kinerja's local office as well as its partner, the Institute for Society and Development Studies (Lembaga Pengkajian Kemasyarakatan dan Pembangunan – LPKP) helped the school facilitate discussions with parents, the school committee, community leaders and representatives from area businesses in order to develop a transparent annual budget.

This open and participatory process not only raised community awareness of the financial difficulties facing the school, but also promoted a sense of ownership of budget they had drafted together. As a result, the school was then able to raise an additional IDR 125 million in donations from parents, community members and local businesses in order to improve the school's facilities and provide extra lessons.

The principal of SMPN 1 Belimbing feels optimistic about the long-term benefits of the school-based management program. "School-based management will boost the schools' power to improve their services and will help them and the community to build a common understanding on the expected education quality," she said.

Workshops held to analyze complaint survey results received strong support from DEOs and local legislators, as well as from school principals and school committees. Several schools were exceptionally responsive to complaint survey findings, even before discussions on service charters got underway. A number of proactive partner schools used complaint survey data and proof of budgetary limitations to raise additional financial support from the community and the private sector. By the end of FY 2014, MSF evaluations of 103 schools found that 78.18 percent of the more than 3,000 service charter pledges had been completed or fulfilled.

2.2.5 Challenges and Plans for FY 2015

In FY 2014, Kinerja encountered several challenges in the implementation of its education program. First, school stakeholders (mainly school committee members) and facilitators have different levels of skill and ability, thus their understanding of governance concepts and the implementation of related activities to address issues that emerged from the complaint surveys has varied. Second, the limited numbers of school staff (especially at primary school level) who can regularly take part in the program required careful consideration in terms of designing activity schedules. Third, the high turnover among DEO personnel made the implementation of policies difficult and often requires additional coordination to ensure positive relationships with district-level policymakers. Kinerja plans to work to strengthen DEOs to promote further consolidation and enhance the program's sustainability.

As in previous years, Kinerja faced technical and non-technical challenges that made PTD more complex than anticipated. From the technical side, valid and up-to-date teacher data proved difficult to obtain. In many Kinerja partner districts, such as Bondowoso and Sambas, technical teams struggled for a considerable amount of time to get valid and up-to-date teacher data, which is crucial to avoiding errors in the teacher distribution plan and its implementation. While calculating classroom teacher distribution for primary schools is relatively easy, the calculations for subject-specific teachers in junior high schools are significantly more complex. Kinerja has managed to successfully address these challenges in FY 2014 with the help of IOs and STTAs.

Non-technical challenges have also made the implementation of teacher distribution difficult as they involved political, social, and economic considerations not only for the district governments but also for the newly elected local legislative members who are not familiar with the approach of the Kinerja program. These issues have been addressed through intensive communications with multi-stakeholder forums, public dialogues and strong policy.

The BOSP program encountered difficulties in Simeulue and Banda Aceh with the continuation of procedural delays and prolonged debates regarding the specifics of the allocation of formula-based BOSP. These debates are indicative of a vibrant and active engagement of a variety of stakeholders, though they have slowed progress in implementation.

MSFs continue to show steady improvement, though building their capacity to function as truly independent centers of public involvement and oversight remains a long-term effort. The frequency of MSF meetings and the attendance numbers had dropped prior to Kinerja's efforts to revitalize MSFs through a selection of new members and the introduction of additional traning.The program's steps to reverse downward trends in productivity have been successful. Challenges remain in maintaining membership commitment, but as has been seen in places like Bener Meriah, key breakthroughs and advocacy victories are possible with continued coaching and support.

Plans for FY 2015

Activities within the education sector for FY 2015 will include technical support on scaling up SBM, continued technical support for the drafting of necessary local implementation plans on PTD and BOSP, and ongoing mentoring support to ensure that implementation plans are drafted and carried out as effectively as possible by SDU and district government actors. With the remaining time of direct support for the education sector, schools and their related MSFs are expected to be able to conduct public complaint surveys, draft service improvement charters and take up any remaining material or policy needs with DEO authorities. District officials, on the other hand, are expected to develop stronger links with SDUs and to enhance their policy drafting and implementation capability through Kinerja support.

2.3 Summary of Progress in Business-Enabling Environment (BEE) Governance

In FY 2014, Kinerja support for One-Stop Shops (OSS) focused primarily on eight treatment districts, and in five of these districts (Melawi, Luwu Utara, Barru, Aceh Singkil and Simeulue) the intervention to support a business-enabling environment (BEE) was implemented as a third component in addition to health and education.

The BEE incentives and innovations interventions can be grouped into three categories: Simplifying licensing requirements and increasing the authority of the OSS; improving the OSS business process; and improving OSS governance. Although Kinerja's direct facilitation to the eight districts in these three categories ended in Q2, there were several achievements reported following that period.

Of the eight BEE districts, Aceh Singkil, Melawi and Luwu Utara achieved the most progress in this reporting period. The first two districts accelerated their progress after slow implementation in the previous reporting period, while the latter continued progressing well as the last district joining the BEE component of the program. Most of the achievements in this reporting period were under the first two categories of interventions – simplification of licensing requirements and increasing the authority of the OSS, and improving business process

– while most of the OSS governance interventions had been completed in the previous reporting period. However, it is worth noting that the district of Barru was selected as a finalist for the prestigious United Nations Public Service Award (UNPSA) for its work to promote a better business environment through Kinerja assistance. In addition OSS reform in Barru was covered by Tempo English magazine in July.

http://magz.tempo.co/konten/2014/07/22/OUT/28598/How-Fare-Public-Services-in-the-Regions/48/14

The Asia Foundation conducted Local Budget Study (LBS) in collaboration with the National Secretariat of the Indonesian Forum for Budget Transparency (Seknas FITRA) that measures the quality of governance throughout the budget cycle and the quality of local budget revenues and spending in 20 Kinerja districts, similar to the one conducted in 2011-2012. The Letter of Grant with Seknas FITRA was signed in June 2014, following which Seknas FITRA organized a briefing on the methodology, design and questionnaires of the LBS to four provincial coordinators and 20 district researchers in Serpong, South Tangerang. Following the briefing, the researchers started conducting the study, including an "accessibility test" – requesting the LGs to provide budget documents in accordance with Law No. 14/2009 on Transparency of Public Information – and collecting other documents such as evidences of participatory budgeting processes, establishment of procurement service unit (ULP), electronic procurement unit (LPSE), and gender mainstreaming working group. Seknas FITRA verified the results of the field work through field visits to East Java and South Sulawesi in September and to West Kalimantan and Aceh in October. It is expected that the findings of the study will be finalized in the next reporting period.

2.3.1 Simplification of Licensing Requirements and Increasing the Authority of the OSS

The basic assumption is that by reducing the types of licenses required – repealing or merging licenses – the burden of private firms to obtain various licenses, and the opportunity of the LG officials to engage in corruption, will be significantly reduced. With the authority for licensing transferred to the OSS, private firms do not need to go to various local government departments (SKPDs) to obtain various types of licenses, while the time, costs and numbers of requirements to obtain them can be reduced and governance improved. Wherever necessary, upgrading the OSS's organizational status – to increase the power of the OSS vis-à-vis other SKPDs – is also supported.

In FY 2014, there were nine local-level regulations that were issued by seven LGs supported by Kinerja simplifying licensing requirements and/or increasing the authority of the OSS.

Local-level Regulations Issued to Simplify Licensing Requirements and/or Increase the Authority of the OSS in BEE Districts in FY 2014

No	Type of Regulation	No.	Date Issued	Description of the Regulation
Simeulue (Aceh)				
1	Regent Regulation	24/2013	Dec 2013	Increasing the authority of the OSS from 12 to 48 types of licenses
2	Regent Circular Letter	5003-005-2014	Jan 2014	Instructing all SKPDs to transfer their licensing authority to the OSS
Aceh Singkil (Aceh)				

3	Regent Regulation	26/2013	Dec 2013	Reducing licensing requirements from 52 to 16 types of licenses
Melawi (West Kalimantan)				
4	Local Regulation	7/2013	Aug 2013 (approved by the PG in Nov 2013)	Repealing 6 types of user-charges (including 4 types of licenses)
5	Regent Regulation	28/2013	Nov 2013	Reducing licensing requirements from 59 to 23 types of licenses and increasing licensing authority of the OSS
Tulungagung (East Java)				
6	Regent Decree	188.45/84/ 013/2014	Feb 2014	Reducing licensing requirements from 104 to 32 types of licenses and increasing licensing authority of the OSS
Probolinggo (East Java)				
7	Regent Regulation	47/2013	Dec 2013	Increasing the authority of the OSS from 29 to 68 types of licenses
Kota Makassar (South Sulawesi)				
8	Local Regulation	7/2013	Dec 2013	Upgrading the status of the OSS from office (*kantor*) to agency (*badan*) and removing licensing function in other SKPDs
Luwu Utara (South Sulawesi)				
9	Regent Regulation	13/2014	Apr 2014	Reducing licensing requirements from 150 to 57 types of licenses and increasing licensing authority of the OSS

In addition to the LG of Barru, which achieved these by the end of September 2013, the LGs of Melawi, Tulungagung and Luwu Utara issued four local-level regulations that reduce the types of business licenses required by the LG and increase the licensing authority of the OSS. The LGs of Simeulue, Probolinggo, and Kota Makassar also issued four local-level regulations increasing the authority of the OSS. Meanwhile, the LGs of Aceh Singkil and Tulungagung issued two local-level regulations to reduce the types of licensing required.

In Luwu Utara, a district head regulation (No. 13/2014) was issued during the reporting period to reduce the types of business licenses from 150 to 57 (including letters of recommendations) and to transfer the licensing authority of all licenses to the OSS. In several sectors, the types of licenses required were significantly reduced – 28 types of licenses in health sector were reduced to three, 11 types of licenses in tourism and livestock sectors, respectively, were reduced to one each, 10 types of licenses in forestry and plantation sectors were reduced to three.

2.3.2 Improvement of the OSS Business Process

There are two main interventions supported by Kinerja to improve the business processes of the OSS: (i) development of standard operating procedures (SOPs) and service standards (*standar pelayanan* or SP) on processing of business license applications and a control card to monitor SOP/SP implementation. The newly developed SOP and SP include specific time, costs, and documents requirements that are shorter, cheaper and simpler than the existing one, if any. The program also supported parallel processing of license applications that would reduce the overall time of licensing even further; and (ii) establishment of OSS technical teams – representatives of SKPDs that are coordinated by the head of OSS to review the technical aspects of license applications – that simplify the licensing process and provide the OSS with full control of the process. In addition, capacity building and training are provided to the OSS staff and technical team members to implement the SOPs, SP and control cards.

In the last period of direct support to the eight districts participating in Kinerja, The Asia Foundation and its local partners were successful in facilitating five LGs in issuing nine local-level regulations that would improve licensing business process, as summarized in the table below.

Local-level Regulations Issued to Improve OSS Business Process in FY 2014

No	Type of Regulation	No.	Date Issued	Description of the Regulation
Simeulue (Aceh)				
1	Regent Decree	503/2014	May 2014	Revision of OSS Technical Team memberships to cover additional licenses authorized to the OSS
Aceh Singkil (Aceh)				
2	Regent Regulation	18/2013	Oct 2013	Allowing parallel processing of license applications
Tulungagung (East Java)				
3	Regent Regulation	22/2013	Aug 2013	Allowing parallel processing of license applications
4	Regent Regulation	4/2014	Jan 2014	SOP on parallel processing of license applications
Probolinggo (East Java)				
5	Regent Regulation	4/2014	Jan 2014	Allowing parallel processing of license applications
6	Regent Regulation	5/2014	Jan 2014	SOP on parallel processing of license applications
Barru (South Sulawesi)				
7	Local Regulation	13/2013	Dec 2013	Dividing the new organizational structure of the OSS into front- office and back office
8	Regent Regulation	7/2014	Feb 2014	SOP to process additional licenses authorized to the OSS
9	Head of OSS Decree	209/KP3M/ 111/2014	Mar 2014	Revision of OSS Technical Team membership to cover additional licenses authorized to the OSS

District Head Decree No. 503/2014 was issued in May 2014 to expand the authority of the OSS technical team to cover all types of business licenses authorized to the OSS that require field visit verification. As discussed in the October-December Quarterly Report, the LG issued a district head decree (*Peraturan Bupati* or *Perbup*) increasing the authority of the OSS from 12 to 48 types of business licenses. In the future, the newly established technical team will be responsible for verifying 42 types of licenses – six others do not require field-level verification – on behalf of the technical departments (*satuan kerja pemerintah daerah* or SKPD) and, hence, simplify the licensing processes.

In this reporting period, the LGs of Aceh Singkil, Simeulue, Tulungagung, Probolinggo, and Barru issued nine local-level regulations that regulate SOP and/or service standards of business licensing, parallel processing of various types of licenses, and establishment or revision of memberships of OSS technical teams. In addition, various capacity building activities were conducted in those five districts and Melawi.

In addition to the improved regulatory framework discussed above, The Asia Foundation and its local partners also supported the Kinerja districts in building the capacity of the OSS staff and technical team members through various capacity building activities, such as:

- *Study tour* to learn from better-operating OSS, such as those conducted by the OSS of Melawi to Kubu Raya, and of Tulungagung to Kota Yogyakarta.
- *Training*, including team building and customer service training for the OSS of Melawi, Tulungagung, Probolinggo, and Barru.
- *Internship program* to allow OSS staff and technical team to work in OSS best practices, such as those of Simeulue and Aceh Singkil who worked for a week in the OSS of Kota Banda Aceh.

2.3.3 Improvement of OSS Governance

There are two main interventions of Kinerja to improve the governance of OSS: (i) development of complaint handling mechanisms; and (ii) implementation of enhanced customer satisfaction (*indeks kepuasan masyarakat* or IKM) surveys. These feedback mechanisms would allow the OSS to improve its service quality. In addition, the program also supports improved transparency of licensing information and better interactions between the government, particularly the OSS, and the people, particularly the private sector, through face-to-face dialogue or through other means, such as radio programs.

In FY 2014, the Asia Foundation and its local partners continued improving business licensing governance through various activities. For instance, a complaint handling mechanism was established in Aceh Singkil through the issuance of a Regent Decree (No. 81/2014) in April 2014.

To better understand the perceptions of their customers about their service quality, the OSS of Luwu Utara and Tulungagung were supported to conduct IKM surveys utilizing an enhanced methodology developed by Kinerja. The latter was implemented through a local university and fully funded by the local budget (APBD). In addition, workshops were conducted to allow intensive interactions among the government, private sector and civil society in Aceh Singkil, Melawi, Tulungagung and Luwu Utara.

2.3.4 Challenges and Actions Taken

In FY 2014, there were three new regulations issued by the national government that may impact the licensing reform agenda:

- KemPAN-RB issued a new regulation (No. 16/2014) that revises the previous regulation on the IKM survey. Although the new regulation provides more flexibility in conducting the IKM survey and the LGs can in fact continue implementing the survey using the methodology developed with support of Kinerja, some LGs perceived that they need to wait for more detailed regulation from the KemPAN-RB on the methodology of the survey, which has delayed the implementation of the planned IKM surveys.
- Presidential Regulation (*Perpres*) No. 97/2014 on OSS Implementation requires integration of the OSS for business licensing and investment and an organizational status of 'agency' (*badan*) for the OSS. While this is a positive reform – ensuring that the OSS is led by an echelon 2 official – this may imply major restructuring of the LG. Another positive reform promoted by the *Perpres* is that it limits the processing time

of basic licenses to seven days, which implies that some of the LGs need to revise their SOP and service standards.

- *Perpres* No. 98 on Micro and Small Enterprises Licensing requires simplification of licenses for micro and small enterprises. The Perpres requires only one type of license for this scale of businesses, without any fees. Furthermore, the micro and small enterprise licensing should be decentralized to the head of sub-district (*camat*). Given that most of the companies requiring licenses in most rural districts fall under this category, the role of the OSS may be significantly changed in the future.

Next Year

In the final year of Kinerja, the Asia Foundation and its local partner and Seknas FITRA will continue implementing the second Local Budget Study, covering all 20 Kinerja treatment districts. The findings of the study will be presented to the Kinerja National Office in Q1 and the overall results will be disseminated in Q3 of FY 2015.

The majority of efforts in the coming year will be focused on supporting replication districts in their implementation of selected BEE components. Further information is available in the replication chapter.

2.4 Summary of Progress in Cross-Cutting Issues

2.4.1 Media

The Kinerja media program in FY 2014 continued to focus on building relationships with mainstream media to cover public service delivery (PSD) issues, and the training and mentoring of citizen journalists. Kinerja also continued to foster links between citizen journalists and mainstream media outlets to provide access to broader audiences and to raise PSD issues that might have otherwise gone unreported.

Mencermati Kematian Ibu-Bayi di Kabupaten Probolinggo

Per Tahun Capai Ratusan

Angka kematian ibu (AKI) dan angka kematian bayi (AKB) saat proses kelahiran di Kabupaten Probolinggo, layak menjadi perhatian. Setiap tahun ratusan bayi meninggal dunia. Apa penyebabnya?

DARI data yang dicatat Dinas Kesehatan (Dinkes) Kabupaten Probolinggo, kasus AKI pada tahun ini mengalami kenaikan cukup signifikan dibanding tahun sebelumnya. Hingga akhir Agustus lalu, tercatat sebanyak 17 ibu meninggal saat proses persalinan. Sedangkan, tahun 2013, kasus AKI hanya 12 kasus.

▸ Baca *Per tahun...* Hal 35

Tahun	AKI	AKB	Total Persalinan
2010	16 kasus	234 kasus	18.906
2011	15 kasus	218 kasus	18.613
2012	15 kasus	230 kasus	18.502
2013	12 kasus	201 kasus	-
2014	17 kasus (Jan-Agust)	122 kasus (Jan-Juli)	-

Jalin Kemintraan dengan Dukun

■ PER TAHUN

sambungan dari hal. 25

Bagaimana dengan Angka Kematian Bayi (AKB)? Tahun ini kondisinya diperkirakan tidak jauh berbeda. Sebagai gambaran, tahun lalu saja kasus AKB mencapai 201 kasus. Sedangkan tahun ini, tercatat hingga bulan Juli lalu, sudah ada 122 bayi meninggal saat proses kelahiran.

Kepala Dinkes Kabupaten Probolinggo dr. Shodiq Tjahjono melalui Kabid Kesehatan Keluarga dan Gizi Ari Suciati mengaku, kasus kematian ibu dan bayi saat persalinan masih tergolong tinggi. Buktikan, tahun ini untuk AKI dipastikan lebih tinggi dibanding tahun sebelumnya.

"Kalau angka kematian bayi belum bisa dikatakan meningkat atau menurun. Karena tahun lalu ada 201 kasus AKB. Sedangkan, tahun sekarang mulai Januari sampai Juli tercatat 122 kasus AKB. Dikhawatirnya, beberapa bulan hingga akhir tahun, kasus AKB malah terus meningkat," katanya kepada *Jawa Pos Radar Bromo*, kemarin.

Kasus kematian ibu saat proses melahirkan ditungkapkan Ari, banyak terjadi di wilayah Kecamatan Sumber, Maron, dan Paiton. Sedangkan, kasus kematian bayi terbanyak terjadi di Kecamatan Dringu. Tetapi, di tiap wilayah kecamatan, ada kasus kematian ibu ataupun kematian bayi saat proses persalinan.

Ari menjelaskan, ada beberapa faktor yang menjadi penyebab banyaknya kasus kematian ibu dan bayi saat persalinan. Mulai dari masih adanya masyarakat yang mempercayai dan memanfaatkan jasa bantuan dukun bayi (beranak) saat proses persalinan. Kedua, peran keluarga yang terlalu berlebihan saat si ibu hamil mengalami gejala. Akibatnya, sering terlambat dalam merujuk ibu hamil dan pertolongan pun terlambat diberikan.

Narnun, di antara beberapa faktor tersebut, yang paling utama adalah pola hidup tidak sehat oleh ibu hamil. Menurut Ari, kebiasaan tersebut bisa akibat pada berkurang gizi dan nutrisi ibu dan janin yang dikandungnya.

Selain itu, pemeriksaan kehamilan yang terlambat juga ikut memberi kontribusi. Karena masih ada pandangan masyarakat, usia kehamilan trimulan pertama, tidak baik untuk diperiksakan. Padahal, pemeriksaan kehamilan harus dari awal sampai pada proses hendak melahirkan. "Angka kematian ibu saat proses persalinan terbanyak pada usia 20 tahun sampai 35 tahun. Itu, kebanyakan karena faktor pola hidup tidak sehat saat ibu tengah hamil," ungkapnya.

Sejauh ini, pihaknya telah melakukan berbagai upaya untuk menekan angka kematian itu. Salah satunya, menjalin kemitraan dengan bidan dan dukun bayi. Lalu, bekerja sama dengan KUA (Kantor Urusan Agama) untuk menyebarkan buku kesehatan calon pengantin, sebagai persiapan sebelum reproduksi.

"Kami juga mengenalkan re; produksi pada remaja. Apalagi, di kabupaten ini kebanyakan lulus SMA sudah langsung menikah," paparnya. **(arif mashudi/aad)**

Kinerja's work to improve maternal and child health through the building of partnerships between traditional birth attendants and medically trained midwives is covered by a regional newspaper in East Java.

In FY 2014, Kinerja interventions in education, health and BEE continue to garner broad media support in both local print and electronic media. Kinerja also saw its work to improve civil society capacity bear additional fruit in reporting on government performance. As of the end of Q3 FY 2014, 27 non-media CSOs had prepared articles on local government performance since the start of the fiscal year, up from just 10 the year before.

In Q4 of FY 2014, a total of 119 citizen journalists produced 282 items on an entirely volunteer basis for distribution through social networks, as well as print and broadcast media. In total, there were 198 citizen journalists that were active at least once during the 12 month period producing a total of 782 items.

During the reporting period, Kinerja supported a fellowship program for local professional journalists in its partnering districts, through which the reporters received funds to write about PSD issues and put the articles live on their media outlets. The objective was to increase exposure of PSD issues to the participants and society. The program trained eight to 10 journalists from each district about PSD issues, two of whom were selected to participate in this fellowship. The program was well-received. One participant in the program, said, "The

training and fellowship program is very important for mainstream journalists like me because it addresses a lot of issues relating to public services such as health and business licensing. The presentations are all clear and data-driven, and are very useful for people like me who don't necessarily have the time to keep up to date with what is happening in the area of public service delivery."

In cooperation with the USAID's ProRep, Kinerja continued its training program about the importance of citizen journalism in the monitoring and oversight of PSD. A training workshop attended by 21 participants from ProRep's CSO partners in Java, Sumatera and East Nusa Tenggara was held on January 27–30 in Depok. This marked second such workshop, with the first held on September, 26–29, 2013 in Bogor, West Java.

In general, progress through FY 2014 remained positive and contributed toward Kinerja's goals of encouraging public engagement with, and oversight of, public services in their communities. Citizen journalists continued to write and broadcast about PSD with the local government responding to some of the issues addressed in the articles. For instance, one article written by a citizen journalist in Aceh Singkil was broadcasted on X-Tra FM radio and RRI Singkil. The piece talks about the district-level MSF's efforts to advocate the DHO to stop village midwives from leaving their jobs. The story elicited significant community response and the topic was even discussed on a radio talk show, following which the DHO issued an instruction for the midwives to stay in the villages and created disincentives to prevent them from leaving their duties.

In Aceh and East Java, several citizen journalists have been recruited by mainstream media as occasional paid contributors. One such writer, Sukriadi, proudly shared his story of transformation – having started from square one with no knowledge of journalism to becoming a paid contributor for a major news outlet. He credits the combination of technical training and public service delivery focus provided by Kinerja's local staff and IO partners with motivating him to become a voice for the people.

Transcription of News, August 30, 2014 edition
104.8 Xtra FM, Aceh Singkil
Report by Sahaf Khadafi

HEALTH COUNCIL ASKS DISTRICT HEALTH OFFICE TO TAKE STRONG ACTION AGAINST MIDWIVES WHO DO NOT LIVE IN THEIR ASSIGNED AREAS

Singkil – The high level of infant mortality in Aceh Singkil in 2014 received special attention from the Health Council of Aceh Singkil, which urged the District Health Office to impose stiff sanctions on village midwives who did not want to stay in their assigned village postings.

This message was conveyed by H. Misbach Kamal, the head of the Health Council of Aceh Singkil at a discussion held at coffee shop supported by KIPPAS on Friday, August 29, 2014. Misbach believes the high number of maternal and child deaths this year cannot be separated from the responsibility of the village midwife, and according to some of the people at the event, the midwife is still largely reluctant to stay in their assigned villages, so that the periodic checkups of pregnant women can only be conducted at neighborhood health posts. This certainly has negative impacts for pregnant mothers in high risk categories.

"The high number of maternal and infant deaths this year must become a serious concern for all stakeholders, chiefly the District Health Office in controlling the performance of village midwives who have already been assigned to an area. If there is a midwife who doesn't stay in the village, he/she must be given a stiff reprimand, because the impact is really bad," Misbach said.

Misbach said that if control visits were done routinely for pregnant women, then potential problems can be anticipated earlier and steps can be taken to prevent bad things from happening.

Not only do midwives need to perform their duties, but the public was also asked to play a proactive role in getting themselves and family members examined.

"Pregnant women also have to recognize the importance of pre-natal checkups, and husbands must be diligent in reminding their wives to go to the doctor or the neighborhood health post for a checkup," he said.

Health problems are common problems, so all stakeholders have to be concerned and work together.

In Bener Meriah almost everything published on *Lintas Gayo* (www.lintasgayo.co) was also broadcast by two local radio stations, namely *Radio Suara Leuser Antara FM* and RRI Takengon. Similarly, in Tulungagung, citizen journalists have been successful in obtaining a daily 12:30 p.m. spot on Liur FM. The same station has also utilized the assistance of citizen journalists during discussion of public issues on the regularly broadcasted talk show "Coffee Morning."

In addition, several citizen journalists have developed plans to ensure that Kinerja's media program remains sustainable. For instance, citizen journalists in Sambas launched a tabloid, *Suara Warga*, and received operational funds from local NGOs and the local government.

2.4.2 Local Government Public Information Officials (PPID)

Kinerja continued to support PPID offices throughout FY 2014 as the local implementers of the national freedom of information law in order to encourage further transparency of the delivery of public services.

Kinerja has successfully facilitated the legal establishment of PPID in all 20 partner districts, and has helped to draft SOPs for the processing of requests for information from the public in the majority of these offices.

During FY 2014, Kinerja supported the establishment of PPID fora in Aceh and West Kalimantan, as a medium for information sharing and coordination among the PPIDs at the district and provincial levels. This effort was undertaken, in part, to support the active replication of PPID beyond Kinerja districts in the two provinces.

2.4.3 Minimum Service Standards (MSS)

Kinerja's support for the application and integration of minimum service standards (MSS) has underpinned its efforts to promote reforms in the health-care and education sectors since the beginning of the program. As Kinerja focuses on consolidation, its work on MSS takes on an even more important role in order to sustain progress and to empower district administrations to carry on in the future.

The goals of Kinerja's technical assistance are to improve the application of MSS in the planning, budgeting, monitoring and evaluation of public services, especially health and education services and to increase the participation of the public and the media in promoting and overseeing the issue of improved governance of health and education services based on national standards.

The quality of public services in the health and education sectors is directly related to the quality of the governance in service delivery. The quality of public services is measured, for one, with indicators and targets related to minimum service standards (MSS), the application of which has been mandated by Law No. 32 Year 2004 on Regional Government and further stipulated in Government Regulation No. 65 Year 2005 on Guidelines for the Preparation and Implementation of Minimum Service Standards.

The focus of Kinerja's technical assistance in MSS continued to focus on efforts to improve local government capacity, especially that of DHOs and DEOs, in partner districts to accelerate their fulfillment of MSS gaps, which have already been identified and integrated into key planning and budgeting documents. By the end of the Kinerja program, it is expected that district partners will have drafted tools and monitoring guidelines to use in evaluating technical departments' achievement of MSS. These tools are expected to achieve two goals: 1.) To

increase the integration of MSS in planning, budgeting and monitoring and evaluation of public services, and 2.) To increase levels of public participation in the promotion and evaluation of governance improvements in health and education services through nationally established service standards.

Based on its Annual Work Plan 2014, Kinerja has focused on 1.) The initial integration of MSS cost analysis into local government planning and budgeting documents, 2.) Increasing local government capacity to conduct monitoring and evaluation activities based on MSS, 3.) The drafting of policy papers to support the creation of national policies on MSS, especially for application at the district level, and 4.) The sustained application of Kinerja's approach to MSS at the provincial and national level, as well as its replication to additional non-partner districts.

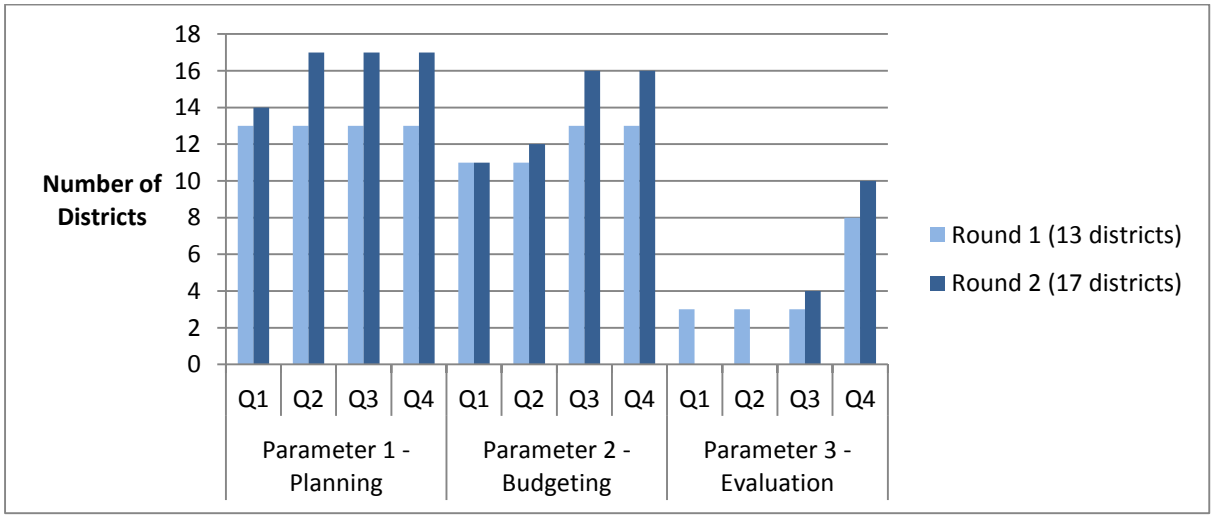
By the end of Kinerja support, the program hopes that all partner districts have the necessary experience and skill to continue planning, budgeting and monitoring and evaluation of MSS achievements.

During FY 2014, the phases of MSS support included:

- Finalizing cost analyses to reduce gaps and designing related strategies;
- Integrating MSS targets and cost analysis into local planning and budgeting documents;
- Monitoring and evaluating MSS achievement;
- Facilitating the sharing of good practices and experiences from the application of MSS at the provincial level;
- And, the internal replication of good practices in the application of MSS within partner districts and the distribution of information about replication methods at the provincial and national level through strategic partnerships.

Progress in the implementation of technical assistance activities on MSS during the reporting period is described in the following table:

Progress of Achievements in Technical Assistance on MSS throughout FY 2014



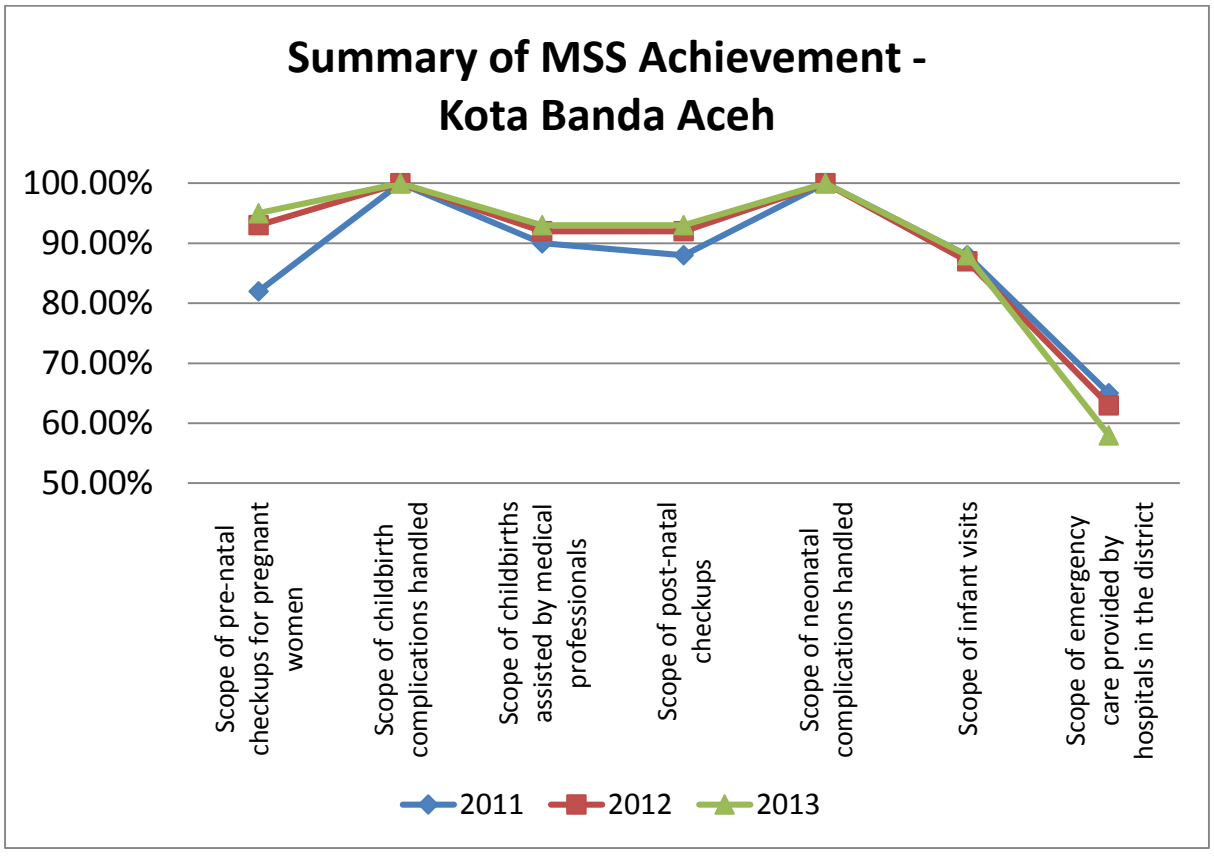
The data above shows that achievements in parameter 1 – related to MSS application in planning process – saw a dramatic jump in Round-2 districts in Q2, While Round-1 districts achieved 100 percent completion during Q1.

The table above also shows that progress in parameter 2 maintained a steadily positive trajectory in both Round-1 and Round-2 districts, though Round-2 showed relatively quicker progress. Only one district, Luwu, has yet to integrate MSS costing results into budgeting documents due to a lack of committed support from the local government.

However, delays slowed the achievement of the target for parameter 3 (evaluation) in both Round-1 and Round-2 districts. collection of data on MSS achievement and data inconsistencies at the technical agency level that delayed analysis (education in Bondowoso). One lesson-learned throughout the year was that collaboration between the district technical offices, the media and the MSF must be improved in order to strengthen capacity in planning and budgeting.

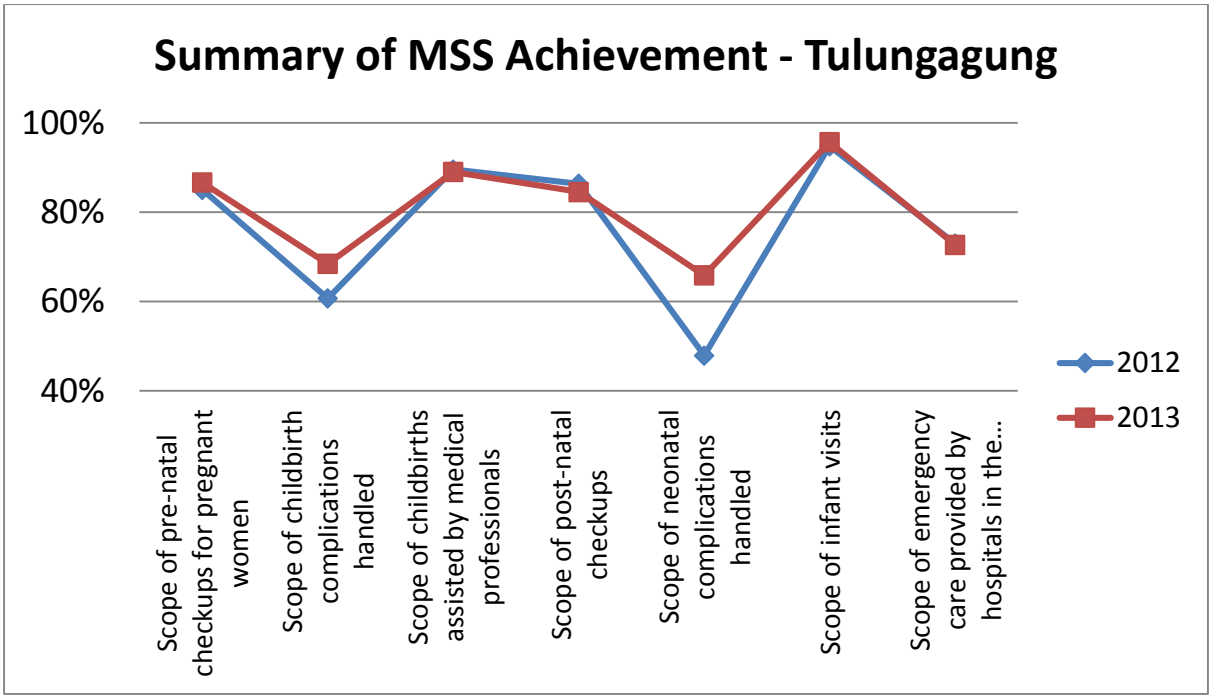
Data became available during FY 2014 to highlight the impact of Kinerja technical assistance in planning and budgeting based on MSS.

In the graphic below, significant gains were made between 2011 (the first year of technical assistance) and 2012 in the Round-1 district of Kota Banda Aceh in terms of improving the achievement of health-related MSS. Based on available data, those gains were then sustained in 2013, showing longevity of the program and an enhanced ability of the local government to repeat and apply the lessons-learned from Kinerja's technical support. Although conclusive data was not available at the time of this writing, the program suspects that the apparent decrease in emergency care services was due to the addition of additional hospitals in the city, which therefore increases the denominator used in the operational definition for this indicator and reduces the percentage of achievement.



A similar trend was seen in the Round 2 district of Tulungagung, where Kinerja assistance led to significant increases in MSS achievement between 2012 and 2013. Though a 2 percent

decrease in post-natal checkups was seen during this time span, program staff consider this to be within the range of normal fluctuations from year to year, and therefore largely insignificant on a policy level.



2.4.4 Gender

Gender mainstreaming remained an important feature of the program throughout FY 2014. Responding to the MTE findings, Kinerja continued to promote gender awareness in all its work. As outlined in the annual work plan for FY 2014, Kinerja focused on improving the capacity of its IOs, stakeholders and local staff to integrate gender-sensitive considerations in all aspects of the project. With this in mind, Kinerja's gender specialist completed the final draft of the gender mainstreaming tools to help IOs and local staff measure gender responsiveness in their activities. This tool focuses on four key factors: access to activities, participation in activities, control of the agenda and beneficiaries.

In addition, Kinerja conducted workshops about gender-sensitive approaches for MSFs in East Java in January, and in Aceh and South Sulawesi in September. In West Kalimantan, Kinerja's IO PPSW addressed gender equity at the service charter monitoring workshop in April. The workshop focused on the importance of community forum members taking into consideration gender when advocating for public services. In addition, Kinerja facilitated a workshop about gender-sensitive program planning, budgeting and evaluation for Luwu district administrators through its IO Essensi in May. In FY 2014, Kinerja made it an IO grant requirement that women constitute at least 30 percent of MSF members.

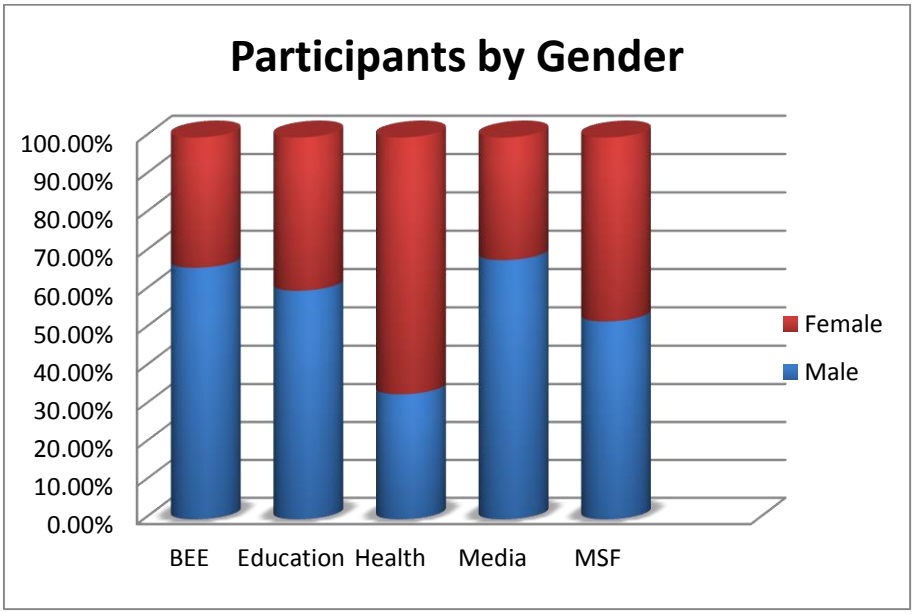
Beyond the gender integration program within Kinerja's districts, the concept of gender equity has been included into the project's replication modules. For instance during FY 2014, Sambas has replicated Kinerja's gender-based adolescent reproductive health program and recruited the project's IO Yayasan Kesehatan Perempuan (YKP) to provide technical assistance.

Although Kinerja developed its gender strategy in FY 2013, it is important to note that the program incorporated gender equity before its gender strategy was even finalized. The

project's work with the Association of Breastfeeding Mothers (*Asosiasi Ibu Menyusui*), Fathers Concerned About Breastfeeding (*Bapak Peduli ASI*) and the series of events with religious and community leaders around breastfeeding has taken aim at a number of barriers to breastfeeding – including support for a woman's choice to breastfeed her children.

In addition, although Kinerja's pilot program for the promotion of reproductive health and the prevention of underage marriage in the East Java district of Bondowoso concluded around a year ago, local stakeholders remain committed to the program's objectives and continue to conduct outreach activities. During FY 2014, the former Kinerja grantees and pilot program participants geared up for the inclusion of reproductive health training in new student enrollment activities.

Male and female participation in FY 2014



As reflected in the chart above, female participation was highest in activities related to health. This corresponds with Kinerja's focus on maternal and child health issues, which have traditionally been the spheres of women. Community participation in MSF sector is now also more gender-balanced, reflecting Kinerja's increased focus on involving more women in public service oversight. Another positive impact has been seen in the MSF structure, where females are increasingly taking on key positions.

In Kinerja's media-related work, female participation in citizen journalism increased slightly from less than 30 percent last year to 36 percent in FY 2014. This increase occurs as more informal media dialogues are set up to make women's participation easier – for instance, the dialogues are conducted in early evening.

Despite the program's progress in terms of gender in FY 2014, there was some delay in the implementation of gender-specific activities due to the resignation of the gender specialist during Q2. For example, the full-scale implementation of the gender mainstreaming tool has been delayed from FY 2014 to Q1 of FY 2015.

While gender equity remains a novel concept for many MSF members, the issues will be addressed by IOs and STTAs in Q1 of FY 2015 so that MSFs can better advocate local governments to provide gender responsive public services. Kinerja will also continue to

strengthen the capacity of IOs and MSFs and encourage them to ensure that all policies promote gender equity.

3. Replication

Now in its fourth year, Kinerja is at the stage where significant success and lessons are appearing in most of its partner regions. Last year, a revised strategy was accepted by USAID, focusing its replication efforts on the existing districts (understood as completion/deepening of the interventions, scaling-up and institutionalization for sustainability) and extension of interventions to an additional 25 districts (10 for health and education combined, 15 for BEE). The program prioritized replication efforts within treatment districts, so that the inclusion of additional service delivery units could work to reinforce the program's consolidation efforts to improve district technical office capacity and ownership of the program's interventions. Kinerja also focused on replication to additional districts within its partner provinces, where the project had considerable influence and was able to plan activities that directly reinforced its aims and involved local actors.

This chapter provides an update on efforts to replicate Kinerja's intervention within districts as packages are scaled-up from pilot projects to broader implementation, and efforts to replicate proven good practices to additional districts within Kinerja provinces and beyond.

Overall at the end of Year 4, 181 health clinics, 409 schools and 261 MSF have been reached by the program. Over 250 MSFs have been formed or strengthened and a total of 237 service charters have been signed and 246 technical recommendations have been made to district level agencies.

3.1 Replication within Kinerja-Supported Districts

In response to USAID RIG Performance Audit Recommendations 1 and 2, Kinerja extended the contracts of 25 short–term technical specialists (STTA) to consolidate Round-1 grants implementation, and issued follow-on grants to Round-2 IOs to support consolidation and replication within partner districts. Kinerja's ongoing support also included activities to strengthen district office staff ability to monitor and manage the programs developed under Kinerja assistance, in order to support long-term sustainability. Kinerja also provided additional support to strengthen district-level MSFs, their linkages to counterparts at the service delivery unit level, and their advocacy efforts to implement service delivery-related programs in health and education.

3.1.1 Health

Progress with existing replication clinics remained positive. In FY 2014, a total of 54 additional *puskesmas* replicated Kinerja's good practices, with Kinerja's good practices replicated 106 times. Within the final quarter of the year, the program saw 10 additional *puskesmas* added to its interventions in each Probolinggo and Luwu Utara, as well as five in Aceh Singkil, four in Sambas, two in Bener Meriah and one in Kota Singkawang.

The good practices replicated in additional *puskesmas* include the implementation of complaint surveys; the signature of service charters; the submission of technical recommendations to district officials; the adoption of Kinerja's approach to building TBA-midwife partnerships; SOPs on patient handling, including for MCH services; and the pre-natal information system known as *kantong persalinan*.

One citizen journalist filed a report from Sambas about the dramatic improvement in services that had taken place once Puskesmas Sungai Kelambu had adopted Kinerja good practices, including dramatically more efficient patient check-in procedures and improvements in staff discipline following the complaint survey and signature of a service charter. The full article can be found (in Bahasa Indonesia) at:

http://kesehatan.kompasiana.com/alternatif/2014/07/06/komitmen-puskesmas-dalam-menjalankan-janji-perbaikan-pelayanan-patut-diapresiasi-672171.html

3.1.2 Education

Kota Probolinggo Gears Up for Good Governance

On Feb. 4-5 more than 30 school principals and district education administrators attended a workshop in preparation for plans to apply the School-Based Management (SBM) program to an additional 99 state elementary and junior-high schools in the city.

Growing out of previous USAID Kinerja support for 20 schools, the two day training-of-trainers event held at the district education office (DEO) aimed to prepare a new cohort of facilitators to coach schools through the proven good governance model.

The event featured sessions on a number of the SBM program's components, including incorporating public complaint survey results, school self-evaluations and minimum service standards into annual school plans and budgets. Principals from previous pilot schools explained how the program had helped them to foster a culture of partnership with the community – partnerships that had then led to major improvements in their facilities and the overall educational environment.

Starting in 2012, the Kinerja program provided technical assistance to elementary and junior-high school principals to develop school work plans in a more participatory process involving local stakeholders, and in preparing transparent, accountable and integrated financial statements. The results from preliminary support were so impressive that government officials from throughout the archipelago and from as far away as Myanmar have sought out the program's partner schools as the subject of study tours.

The director of basic education at the DEO, said, "With support from USAID Kinerja, we've achieved great results thus far. The schools that partnered with this program in the 'pilot' phase are far better than they ever were before. What we want to replicate is not just the physical improvements to infrastructure, but also the method of strengthening management skills and incorporating public input and oversight."

The head of curriculum and student development in the DEO's basic education department said, "This training has been really useful for me in terms of deepening my understanding of not only what the SBM program is, but how it is applied in practical terms."

Throughout FY 2014, a number of Kinerja-supported districts rolled out the SBM program to additional schools using local government funds and technical assistance from IOs and STTAs. By the close of the year, 149 additional schools had adopted good practices from the program. Additional developments got underway, but had not resulted in document outputs needed to qualify as an achievement in the PMP table attached as Annex A-2.

This significant achievement was built on the strong commitment of local partners like Probolinggo, which replicated the education package to all primary and junior high schools and allocated IDR 257 million in the annual district budget to support the program. The district of Barru replicated SBM in 40 schools using funds from the 2014 district budget. Kota Probolinggo and Jember have also shown deep levels of dedication to the SBM program, and were supported, through TOT workshops and other activities to strengthen the role of the DEO in managing and overseeing schools, with a focus on incorporating good governance with technical improvements.

In an effort to increase district-level ownership of its initiatives, Kinerja assisted the DEO in Bener Meriah to finalize its executive decision on the appointment of 10 replication schools on April 10. To assist schools with the expansion of the SBM program, Kinerja facilitated a TOT in Bener Meriah on April 28. The SBM package has received a great deal of support from the

local legislative council (DPRK), and the district has now replicated the program to 10 schools after providing a budget of IDR 122 million.

In Sambas, the local administration recruited LPKIPI (IO) to assist them to expand the SBM program to 100 schools.

With the shift of the project's focus to the replication districts in Q1 2015, Kinerja is planning to gradually phase out its activities in these districts as they are considered already mature in implementing the SBM package. It will continue to provide follow on support to further consolidate district –wide implementation in the following districts: Bengkayang (SBM), Bondowoso (PTD) and Simeulue (BOSP).

3.1.3 BEE

As OSS office operations provide district-wide coverage, within-district repetition is not possible within the BEE component. However, encouraging results are already emerging from the package's adoption in districts outside of Kinerja's coverage (please see below).

3.2 Replication to Additional Districts

Responding to the findings of RIG audit, in FY 2014 Kinerja focused on consolidation of Round 1 and 2 grants and scaling up the intervention to non-partner districts.

During the reporting period, Kinerja made significant progress in replicating its good practices to districts outside the project jurisdiction. By the end of the fiscal year, 35 non-partner districts replicated Kinerja's packages – including 18 districts in Aceh, 12 districts in South Sulawesi, three districts in East Java, and two districts in West Kalimantan.

Of these 35 districts that adopted Kinerja components, 11 did so in the last quarter of the year – including eight districts in South Sulawesi, two in East Java, one in West Kalimantan.

Kinerja's work to prevent underage marriage and promote adolescent reproductive health education has been replicated in Sambas, West Kalimantan, and has been adopted for use in Mimika, Papua

Overall, the districts adopted 74 Kinerja good practices in FY 2014, with 36 of those good practices adopted in Q4. The good practices achieved in Q4 include 18 achievements in Aceh including replication of health and BEE good practices; two achievements in East Java related to the replication of BEE good practices; two achievements related to the replication of BEE good practices in West Kalimantan; and 14 achievements in South Sulawesi including the replication of BOSP and BEE good practices.

The high commitment of the replicating districts to adopt the program was reflected in the district budget amendment to incorporate Kinerja's packages. For example, Pacitan revised its budget for 2014 to allocate IDR 50 million for the school based management (SBM) implementation and provided IDR 100 million to support pregnancy classes as part of Kinerja's safe delivery program. In addition, several replicating districts hired Kinerja-supported IOs to assist them with program implementation. In East Java, Kota Mojokerto and Mojokerto recruited LPKIPI to provide them with technical assistance in SBM.

In FY 2014, Kinerja signed Memorandums of Understanding (MOUs) with 30 districts. With the assistance from the project and One-Stop Shop (OSS) provincial forum, the districts have produced 38 district level regulations increasing the authority of OSS authority – Aceh (10

regulations), West Kalimantan (five regulations), East Java (four regulations) and South Sulawesi (19 regulations).

As discussed in the previous quarterly report, the remote location of some districts replicating BEE components has posed a challenge that has limited the intensity of the IO. On the other hand, the commitment of the LGs' officials in promoting licensing reform has not been as strong as expected. IOs dealt with this issue by raising the attention of higher level officials within the LGs. As shown in the box below, some of these efforts were successful in accelerating the process, although in another case, the challenge has not been fully resolved yet.

As for the replication of PPID in Aceh, Kinerja supported three replicating districts (Aceh Barat, Pidie Jaya and Aceh Tamiang) to issue guidelines on public information sharing that they signed in this quarter. Furthermore, 15 of 18 districts in Aceh allocated budget for PPID activities in 2014. In addition to the guideline preparation, Kinerja's local staff trained PPID facilitators at province level with expectation that the facilitators would be able to assist district-level PPID after Kinerja is phased out. To further strengthen replication efforts in Aceh, Kinerja began the early stages of cooperation with the German-based Web Foundation to enable the districts to establish open data system that would help local governments to provide information in a timely manner.

Given that Kinerja's assistance will end in 2015, external replication does not focus on the whole program implementation, including evaluation cycles post-implementation. For instance, Kinerja's assistance to BOSP in Kota Batu will stop at the regulation issuance and integrating the BOSP calculation into the district plan. Kinerja will work through existing forums and government technical teams to conduct province-wide replications, such as BEE forums and technical team in East Java. At the district level, the project will encourage the replication districts to recruit Kinerja IOs and provide assistance through STTAs.

3.2.1 Replication Workshops

Kinerja sees provincial-level actors and activities as key points of leverage for the further replication of its good practices. Accordingly, during the reporting period, it held a number of activities and workshops to ensure the broader adoption of its approach. All the replication workshops took place in the first three quarters of FY 2014, with Q4 dedicated to technical assistance.

In East Java, Kinerja and its IOs held a seminar and dissemination event on Oct. 28-29, 2013, to share good practices from its five partner districts in East Java to potential replication districts from the province. Based on previous Letters of Interest (LOI) and additional confirmation, those districts included: Banyuwangi, Blitar, Kediri, Kota Batu, Kota Kediri, Kota Malang, Malang, Pamekasan, Pacitan, Pasuruan and Situbondo. This replication activity helped to ensure that potential replication districts were well-informed about the Kinerja program of their interest and established preliminary coordination with Kinerja IOs. Due to budget limitations for 2014, many of these replication districts choose TOTs with follow-on coaching and mentoring support, rather than a full technical assistance package with an NGO partner. Many replication districts committed to allocating additional funding in their 2015 budgets by including technical assistance as an agenda item for discussion in *musrenbang* (community planning meetings) this year.

In Aceh on Nov. 25, Kinerja facilitated a workshop on Government Administration SOPs at service delivery units (public health facilities and PPID) for the district administration of Gayo Lues, as part of Kinerja's replication effort. After the workshop, 135 SOPs were identified from 45 SKPK (district working units) in Gayo Lues to be drafted. Kinerja focused its support on 15 of these SOPs that focused on pre- and post-natal care and expects drafts to be signed in early FY 2015.

In the early part of the fiscal year, Kinerja held a workshop in the district of Gayo Lues to follow on the administration's request for technical assistance. As a result, district decision makers drafted a MOU and work plan to adopt Kinerja's programs. The district has already earmarked IDR 507 million in its 2014 budget, and recruited Kinerja IO staff to help support implementation.

On Feb. 25, Kinerja's office in East Java met district planning agencies from across the province and presented its programs. The provincial planning agency confirmed its commitment to supporting Kinerja replication throughout the province, and as mentioned in the sections above, several districts have expressed an interest in adopting the project's packages, including Banyuwangi, which plans to implement all three sectoral programs.

As part of Kinerja's strategy to sustain its programs in East Java, the project supported a TOT about improving public service delivery through good governance for the provincial technical team on May 6. Having attended this training, the participants, who also represented various governmental bodies in East Java, committed to provide further assistance for the local government to adopt Kinerja's packages. Kinerja staff was surprised by the level of participation and enthusiasm of attendees. There were a total 80 participants from seven districts who joined the sessions on MBS and health. The district of Pacitan, which is located 6 hours of travel time from the venue and will replicate Kinerja's MBS approach, attended the activity with 15 people consisting of elementary school principals, as well as officials from the Local Development Planning Board (Bappeda) and the DEO. The activity also drew great support from provincial actors, especially the Administrative Bureau as well as the Organizational Bureau of the East Java provincial government. The first day of the TOT concluded at 9:30 p.m. due to the level of participants' enthusiasm.

MSFs revive town hall tradition

On April 3, Kinerja IO ESSENSI supported the first-ever *Sipulung Tudang*, or town hall meeting, on standards-based public services in Kota Makassar.

Modeled on traditional community meetings in South Sulawesi, the Kinerja-supported event drew in more than 150 participants, including high-ranking decision makers, to discuss public service issues and the importance of public participation in the enactment of improvements.

During the meeting, the secretary of the city administration spoke on behalf of the mayor Ilham Arief Sirajuddin, while Syamsu Rizal, who was sworn in as deputy mayor in May, talked about improving the quality of public services, with a particular focus on health, education and business enabling environment. In addition, MSF used the occasion to present eight recommendations for public service improvements such as community involvement and implementation of feedback mechanisms.

Similar events were held in the four other South Sulawesi districts in the weeks that followed.

3.2.2 Provincial Forums

The main replication strategy of The Asia Foundation and its local partners in the BEE component is to support the provincial governments (PGs) participating in Kinerja to: (i) facilitate the establishment of a forum of district-level OSS in each province (OSS forum) that will reach non-Kinerja districts; (ii) regularly evaluate the performance of the district-level OSS in each province through the Provincial OSS Performance Index (POPI) surveys; and (iii) utilize the results of POPI to create incentives to improve the performance of the district-level OSS through peer-to-peer learning. This strategy is expected to strengthen the

main role of the PG of monitoring and facilitating the LGs. In addition, peer-to-peer learning – based on real experience of similar units of government in the area – is considered to be more effective than learning from "outsiders" such as the national government.

Aceh: BITRA, together with the Provincial OSS Forum, facilitated a three day workshop on complaint handling mechanism in Sabang in June 2014. The workshop was attended by 12 participants (two women) from four replication districts Aceh Timur, Aceh Selatan, Pidie Jaya, and Kota Subulussalam. The participants of the workshop were facilitated to discuss general concept and develop mechanism to manage complaints, including categorizing the types of complaints, developing flowchart and identifying personnel to be in charge of managing complaints. It was agreed that the four LGs would formulate local-level regulations that would be further discussed with the group.

In FY 2014, BITRA conducting three workshops on SOPs for processing license applications (Oct. 2013), complaint handling mechanism (June 2014) and on simplification of types of licenses and customer satisfaction index (IKM) survey (Aug. 2014) to help five replicating districts - including Aceh Jaya, South Aceh, East Aceh, Pidie Jaya and Kota Subulussalam – to improve their licensing services. The last workshop was attended by 30 OSS officials, of whom nine were women, from the five districts.

The 2013 Provincial OSS Performance Index (POPI) results were disseminated in Q4 though an OSS Forum event attended by 42 participants, seven of whom were women, from all districts in Aceh. This delay was caused by the replacement of the Head of Provincial OSS.

In addition to disseminating POPI results, the OSS Forum event was also used to disseminate two newly issued national regulations on OSS implementation and licensing for micro and small enterprises.

West Kalimantan: Madanika held workshops on SOP and service standard formulation in Nov. 2013 and on license mapping in May 2014. The May workshop was attended by LGs in the provinces, with the main agenda of discussing investment mechanism and international trade, with resource persons from the National Agency for Investment Coordination (BKPM) and the Ministry of Trade (MoT).

In Q4, Madanika conducted two interdisciplinary workshops. The first one, which was held in Sept. in Pontianak, was on formulation of SOP for processing license applications and complaint handling. The workshop was attended by 13 OSS officers (three women) from two replication (Kapus Hulu and Ketapang) districts and two scale-up districts (Sambas and Bengkayang).

Madanika supported the Provincial Governments (PG) to update POPI data in the first half of FY 2014. As reported in the January-March 2014 quarterly report, the results of the 2013 POPI were disseminated in an OSS Forum event in February 2014. The results show improved performance of Melawi, Kabupaten Pontianak and Kota Singkawang relative to other districts. In addition to disseminating POPI, the OSS Forum held in February 2014 was also used to discuss improvement of business licensing through various interventions promoted by Kinerja.

East Java: The strategy adopted by PUPUK Surabaya in promoting the replication of BEE interventions has been to conduct a series of workshops that cover several nearby districts in the province ("sub-provincial workshop"). Five sub-provincial workshops were held in the October 2013 - June 2014 period: a workshop on transferring of authority for four LGs in Bondowoso area (November 2013); three workshops on formulation of SOPs for 14 LGs in Kediri area (October 2013), for eight LGs in Blitar area (October 2013), and for four LGs in

Banyuwangi area (December 2013); and a workshop on licensing authority and SOP formulation for five districts in Trenggalek area (June 2014). In addition, PUPUK Surabaya supported the Provincial OSS Forum to implement a POPI survey in October - December 2013. The findings and recommendations of the survey were presented to representatives of all LGs in the province in a workshop in December 2013.

In Q4, PUPUK Surabaya held two additional sub-provincial workshops. The first one was held in Lamongan in July 2014 and attended by 72 officials (eight women) from six districts. The workshop discussed transfer of licensing authority to the OSS and SOP development, with resource persons from Airlangga University (Surabaya) and an official of the Ministry of Home Affairs (MoHA) and facilitators from PUPUK Surabaya. The second one was held in September 2014. This workshop discussed simplification of licenses and transfer of licensing authority to the OSS, with a resource person from Airlangga University, the Head of the East Java Provincial OSS and a consultant of The Asia Foundation. There were 60 participants (ten women) from the 14 LGs in the province (including non-replication districts).

South Sulawesi: YAS, in collaboration with the PG's Organizational Bureau and the OSS Forum, held five inter-district workshops (mainly attended by the replication and scale-up districts) in the first three quarters of this reporting period: (i) on formulation of complaint handling mechanism (November 2013); (ii) on license simplification (March 2014); (iii) on strengthening OSS institution and OSS technical team (April 2014); (iv) on SOP formulation (May 2014); (v) on complaint handling mechanism and collaboration with the Coalition of Public Service Monitoring (KLP-KLIK) in June 2014. The last is a follow-up of an MOU signed by the OSS Forum, Provincial Ombudsman Office, and KLP-KLIK at the Provincial OSS Forum in January 2014.

In the last quarter of FY 2014, YAS conducted another workshop on license simplification in Makassar in September 2014. The workshop was attended by 26 officials (9 women) from nine LGs. YAS facilitated the participants of the workshop to learn from the experiences of three LGs in the province, Sinjai, Soppeng and Barru. A brief guideline on license simplification was developed in the workshop and will be utilized by other LGs in 2015.

3.2.3 Replication in Cooperation with Development Partners

In cooperation with the Ministry of Home Affairs and the Canadian International Development Agency's (CIDA) Basics program, Kinerja disseminated its good practices in applying minimum service standards in health and education, within the framework of the MSS modules that were developed jointly this year, to audiences in Southeast Sulawesi and North Sulawesi, respectively on May 5-6 and May 7-8. In these events, Kinerja also promoted two of its NGO partners – KOPEL and LPKIPI – in health and education, respectively, to the local governments that attended.

During FY 2014, Kinerja cooperated with the Ministry of Home Affairs and the Canadian International Development Agency's (CIDA) Basics program to prepare a series of resource booklets related to the application of service standards in local government planning and budgeting processes for use by the Ministry of Home Affairs. Through this cooperative arrangement, nine Kinerja good practices regarding the adoption of MSS were featured in two of the eight booklets, which were distributed to all districts nationwide. An official book launch event took place in April, and Kinerja used follow-on regional events in South Sulawesi and North Sulawesi, in May to promote two of its NGO partners – KOPEL and LPKIPI –to the local governments that attended.

3.2.4 Cooperation with Private Sector / CSR Funding

Following up on its effort to engage Java Power in supporting public service improvements in East Java through its CSR program, Kinerja facilitated the first training on complaint surveys and baseline surveys for health volunteers at Puskesmas Paiton, a clinic supported by the utility firm, on April 15. The training went well and the participants engaged in lively discussions. The head of the district health office's family health division and the MSF coordinator, Ari Suciati discussed survey questions and interview techniques with eight training participants. Kinerja's collaboration the utility firm continued to bear fruit as the program facilitated the establishment of a multi-stakeholder forum at Puskesmas Paiton on April 22. The survey was conducted in late April and early May, involving roughly 150 respondents. Workshops were also facilitated to analyze the survey results, and a service charter was drafted in May. The service charter was then signed in early September, following the Idul Fitri celebrations that mark the end of the holy fasting month of Ramadan.

As a result of its hard work, and in validation of the program's approach, Puskesmas Paiton has been recognized in local media for its adoption of improvements in patient handling. Following the example set by Kinerja partner Puskesmas Sumber Asih – which was recently recognized by the provincial government as the second-best *puskesmas* in East Java – Puskesmas Paiton installed fingerprint scanner to reduce patient check-in times and to integrate medical records, insurance and billing information into an integrated, paperless database.

3.3 National-Level Replication Efforts

3.3.1 National Policy Dialogue on Service Standards

Throughout FY 2014, the Ministry of State Apparatus, Empowerment and Bureaucratic Reform (KemPAN-RB) underwent a process of revising its regulations on the development of customer satisfaction indexes (IKM) at the service delivery unit level, improving public services through community participation (complaint surveys), and on service standard. At the time, Kinerja was invited to participate this review process and provide input based on its experience in the field.

Kinerja was ultimately successful in convincing the ministry to keep complaint surveys and other public oversight mechanisms in the current draft regulation on community participation, because of the demonstrated impact its own surveys have shown on public service improvements. On May 2, KemPAN-RB published new regulations that reflected the input and advocacy Kinerja put forth.

3.3.2 LAN Cooperation

Kinerja works with the State Administrative Bureau (LAN), which encompasses the national training center for government staff, to achieve wider replication of its programs. In FY 2014, LAN began a process of revising its curriculum and training guidelines, and is planning to adopt Kinerja's training manuals, which are based on empirical findings from Kinerja case studies. Kinerja service delivery modules include information on how to establish a partnership between civil society and local governments including the use of feedback systems, citizen oversight, and methods for local governments to be accountable and for citizens to demand better services.

In FY 2014, Kinerja focused on familiarizing LAN with its activities through several joint visits to Kinerja partner districts with high-level LAN decision makers. In addition, Kinerja invited

LAN staff to provincial replication workshops and training sessions where they got first-hand information about good practices. Kinerja facilitated a one-day training on improving public service delivery through good governance for master trainers from LAN and other technical ministries on May 14. A three-day training course for LAN's master trainers on the national and provincial level also took place on August 19-22. Kinerja incorporated short films on its work in the districts of Barru, Luwu Utara and Aceh Singkil to help government staff understand both the needs at hand and the import contributions made by incorporating good governance mechanisms. As a result, LAN committed to changing its overall training strategy from a simple recitation of rules and regulations to Kinerja's more practical approach, which it believes enables local government staff to improve public services.

Kinerja is currently working with LAN to revise the Head of State Administrative Agency Decree (PERKA LAN) No. 10/2011 on the 'Guidelines for Implementation and Education for Public Service Delivery' that outlines LAN's curriculum. The focus of Kinerja's effort is to make the training sessions more practical and relevant by incorporating case studies from Kinerja districts, introducing aspects of competency-based curriculum, and developing different training for various target groups, including management and front-line service.

3.3.3 National Good Practice Workshops

Kinerja organized the Symposium on Innovation in Public Service Delivery which took place at Jakarta's Sahid Jaya Hotel on June 16 and 17 in collaboration with KemPAN-RB and a broad range of international development partners. The symposium, which drew over 500 participants from around Indonesia, provided districts the opportunity to showcase their achievements, and discuss how central and provincial governments can ensure sustainability and replication of good practices. It further addressed efforts for replication of good practices such as competition, financial incentives, national regulations, policies. Notable guests at the symposium included Indonesian Vice President Boediono who opened the event; Administrative and Bureaucratic Reform Minister Azwar Abubakar, who presented the key note speech; Vice Minister Prof. Eko Prasojo and US Ambassador to Indonesia Robert Blake. A total of 54 resource persons from across Indonesia spoke during two talk-shows, nine discussion rounds and one lecture about their experiences with public service innovations.[4] A total of more than 500 invited Symposium participants got involved into lively discussions, forwarded their questions and articulated some conclusions.

During the event KemPAN-RB provided the five United Nations Public Service Award (UNPSA) finalists with certificates of appreciation and invitation were given to attend the Award Ceremony in Seoul together with KemPAN-RB. The symposium ended with a handing over of summary findings and recommendations to KemPAN-RB, which will guide future cooperation between the ministry and the donor community. The event included as well an exhibition from various national and local governments. Kinerja IOs were as well able to market their programs and established links with interested governments. The event was covered in various media articles, among others in *Tempo Magazine*, *The Jakarta Globe*, and *Kompas*.

[4] The detailed workshop documents, including the PowerPoint presentations by different resource persons and other materials, are available online at:
https://drive.google.com/folderview?id=0B6kJghcYHpScbHFIWlg5clV1OVU&usp=sharing.

Following up on the symposium, a working group was established together with LAN, APEKSI, GIZ and Kinerja to draft a new decree on public service innovation. The first draft of the decree was discussed on Oct 8. Significantly, KemPAN-RB has committed to following up on the symposium's recommendation to develop regional innovation hubs to further support innovation in public policy.

3.3.4 Cooperation with KemPAN-RB

In addition to its cooperation through ministerial policy revisions, Kinerja responded to a request from KemPAN-RB for information to support the nomination of three partner districts (Barru, Aceh Singkil and Luwu Utara) for the United Nations Public Service Award (UNPSA). KemPAN-RB sought to nominate these districts based on their respective achievements in improving business licensing, fostering TBA-midwife partnerships and proportional teacher distribution. Five Indonesian districts were selected as finalists, which was the first time in history any Indonesian nominee had proceeded to the final round. Three out of these five were Kinerja partner districts.

KemPAN-RB representatives attended the official awards ceremony, held in Seoul, South Korea, and funded the attendance of a representative from each Indonesian finalist as an opportunity to learn more about international best practices and to strengthen the applications of future Indonesian nominees.

In FY 2015, Kinerja plans to support KemPAN-RB to nominate five districts – including updated nominations for the previous three finalists along with two new districts – for the 2015 UNPSA award ahead of the November deadline.

3.3.5 IO Capacity Development

Kinerja conducts a considerable amount of capacity development to qualify the IOs as future multipliers of the Kinerja development programs, which includes orientation workshops and in-depth technical and administrative/financial briefings and trainings. The IO workshops provide technical guidance on the tools and methodologies that would be used in implementing Kinerja packages and support the IO to develop detailed work plans. They also introduce the Kinerja activity reporting system and familiarized participants with the indicators they have to help to achieve.

During round 1 grant implementation, Kinerja worked with national and province level CSOs. During implementation, it became apparent that many of these organizations lacked management capacity and had problems in overseeing district level implementation in many of the remote regions where Kinerja is working. As a result, during round 2, Kinerja tried to as much as possible identify CSOs on district level. The downside of this was that their capacity was often weak and they needed a lot of additional backstopping, which made additional capacity building workshops and frequent mentoring and on-the job trainings necessary.

In FY 2014, Kinerja held a variety of capacity-building trainings for its IOs, including workshops during the April-June quarter, focusing on organizational development and leadership training, and on administration, finance and grants. Additional training on technical aspects of the program's education and health governance packages was conducted Sept. 2–4. During this three-day workshop, all IOs in both the health and education sectors had the opportunity to share good practices as well as challenges and related strategies for overcoming obstacles.

A total of 19 CSOs developed marketing strategies this year, which clearly outlined their plans to work with and advocate to non-partner district governments toward the improvement of service delivery, thanks to Kinerja support. Four of those CSO's developed their marketing strategies in Q4, including: LPKP, Yapikma, JPIP and Bitra.

This year, Kinerja's grantees forged a total of 52 formal partnerships with district governments to support the replication of good practices. These formal engagements between civil society and the government represent an avenue through which replication can occur and sustainability can be ensured. Seven of these engagements were noted during Q4. These agreements include the following districts, disaggregated by Kinerja province:

- Aceh: 3 engagements regarding health
- East Java: 1 engagement regarding health
- South Sulawesi: 1 engagement regarding BEE
- West Kalimantan: 2 engagements, 1 regarding health and 1 regarding BEE

Kinerja also made progress in the development of modules that document Kinerja good practices, that encourage innovative thinking and guidance for improved public service delivery. In FY 2014, the Kinerja program finalized nine modules that contain 15 good practices. Three modules were finalized in Q4: Safe Delivery; Immediate and Exclusive Breastfeeding; and Advocating for MSS. These modules were reviewed by external consultants, finalized by the Kinerja team. They were used as reference during various partner trainings and shared with relevant stakeholders (including partner and non-partner district governments). Four achievements were noted for Indicator 23, representing four good practices that are contained in the three modules.

3.3.6 JPIP/FIPO/PPIP Pro Autonomy Awards

As part of its efforts to replicate good practices, Kinerja continued to support Jawa Post Institute for Pro Otonomi (JPIP) in East Java and its sister program in South Sulawesi run by the Fajar Institute of Pro-Otonomi (FIPO) to continue their research efforts and ongoing work in recognizing top-performing district administrations.

These prestigious awards programs are aimed at using a blend of public policy research and media attention to spur innovation in public service delivery, improve the performance of existing programs and replicate proven good practices to new districts. Through their extensive documentation, these programs have become a repository of information on successful reform efforts at the local level.

JPIP and FIPO have used the power of their media groups to publicize good practices throughout the year by dedicating a full page of coverage every two weeks in their respective newspapers. This continuous focus has helped to increase access information about good practices, to boost the pride of well-performing districts and to create strong incentives for other districts to achieve similar results.

The deputy executive director of JPIP, said, "We push district governments to compete in improving public services with our approach by providing recognition for their performance…This has also become a large motivator for district leaders because this has also become a measurement of their performance. They were elected in local elections, but from there they also have to prove their performance through the autonomy awards, for example."

Kinerja's ongoing support for JPIP and FIPO also included a focus on the expansion of provincial awards programs to West Kalimantan. Drawing on their extensive experience in running similar programs, JPIP and FIPO were instrumental in the establishment of the Pontianak Post Institute of Pro-Otonomi (PPIP), which held its first annual autonomy awards ceremony on Dec. 14.

In general the Autonomy Awards receive high levels of attention from national government. The JPIP Autonomy Ceremony was attended by cabinet-level ministers.

Indonesia's Deputy Minister for Bureaucratic and Administrative Reform said, "We at the ministry fully support initiatives like the PPIP Awards program, and I am excited to attend the inaugural event in West Kalimantan. I expect this program to help highlight successful reform efforts and innovations in the delivery of public services. By pointing out what is possible, the PPIP Awards program helps to raise the bar for government performance so that decentralization can deliver the maximum possible benefit for the people."

The PPIP Award Ceremony recognized nine districts (with 12 awards) that have successfully faced challenges associated with decentralization and service delivery in three main categories – economics, public services and political performance. On the night, Bengkayang won a silver trophy in the Administrative/ BEE Services category.

A recent JPIP study, commissioned by Kinerja, found that autonomy awards are an effective means of promoting innovation. The study looked at the sustainability of innovations in 38 East Java districts that have received an award for PSD improvement in the past 12 years. Out of the 55 innovations recognized throughout this period, 47 have continued or have been expanded and only eight have been discontinued. The study also provided evidence that innovations were initiated and sustained frequently by district heads and their administrations. Very few innovations had been encouraged by outside influence, e.g. the national government, provincial government or development partners. It is noteworthy that no good practice has been initiated by DPRD in districts in East Java over the past 12 years.

The results of the study validate Kinerja's combined supply and demand approach, and its cooperative nature of implementation. The three most significant aspects that encourage local governments to provide good service delivery include the leadership of the SKPD and the head of the region, as well as community support. The study emphasized the need to:

- Incorporate meaningful public feedback in policy initiatives;
- Support leadership who prioritize performance improvements;
- And, select and maintain managers capable of driving innovations and inspiring improvements in public service delivery.

The next round of awards ceremonies is slated to begin in early FY 2015, and Kinerja expects that now with sufficient supporting documentation, a number of its treatment districts stand excellent chances of being recognized for their performance.

4. Project Management

4.1 Second- and Third-Round Grants

4.2 Second- and Third-Round Grants

Kinerja aims to ensure sustainable change by developing local capacity to implement the program's innovation packages. It does this by implementing programs through local CSOs. In FY 2014, 25 grants were provided to CSOs. Throughout the lifetime of the project so far, a total of 63 grant agreements have been implemented (for details see Annex A-4).

Following the direction of the RIG Audit, which included a recommendation for a solid consolidation of the program, Kinerja extended the round-2 grants by an additional year. At the time of reporting, follow on grants for a total of 20 IOs had received approval: five education grants, six health grants, four BEE and five Media/Pro Autonomy Grants. An additional four new grants were awarded to support district level MSFs, along with one grant for a repeat of the local budget study.

RTI issued 16 follow-on grants: five grants for education sector, six grants for health sector, five grants for media sector and four new grants for district level MSF support. The Asia Foundation awarded five grants.

4.3 Cost Share

The overall cost share commitment for the project amounts to $5,846,902. With the increasing number of development partners in Papua paying local governments for participation in their project activities, it has become a huge challenge for Kinerja to raise the initial committed 20 percent cost share contribution in Papua. At the same time the Kinerja Core program has reached a very mature stage, in which local governments see the benefit of working with the program and are readily allocating their funds. The program has also entered the stage of district-wide replication in the main program, and local government partners have allocated huge amounts of their own funding for project-related activities. For this reason, Kinerja had approached USAID to reallocate some of the Papua cost share obligations to the Kinerja Core program.

At the outset of the fiscal year, Kinerja proposed a revision to its cost share commitment for the whole five-year program, increasing the amount to be raised through Kinerja Core.

Between October 2013 and September 2014, Kinerja Core far exceeded its annual target in cost share, a majority of which, as explained above was received through local government contributions. This figure brings the total cost share achieved so far to 119 percent of the program's overall cost share obligation.

5. Summary of Challenges and Next Steps

The progress described in the chapters above has not been without significant challenges. In FY 2014, government staff turnover continued to be a persistent challenge. While in principle, routine staff rotations are designed to prevent the emergence of rent-seeking behaviors, in practice, it makes the establishment of programmatic continuity a continual struggle.

The 2014 election cycle both served as a momentous occasion in Indonesia's democratic history and as a significant distraction to the project's activities and staff.

Although overall progress was positive in the implementation of Kinerja's education packages, a number of challenges were identified that hindered achievement of program goals in education. Procedural delays from local government partners have prevented the passage of key supporting regulations and budget resources needed to proceed with the implementation of

the BOSP and PTD packages. MSF involvement in the SBM package continues to show progress, but always has room for further improvement.

The strengthening of MSFs in most regions is a long-term investment. Educating MSFs, helping them to formulate their concerns and needs, and putting them in an oversight role involves a significant amount of effort to foster a change in mindset and requires steady mentoring support.

Replication has been delayed by a focus on consolidation as a result of audit findings, and by the need to follow the annual cycle of budget planning. As a result of these two factors, in many of its replication districts, Kinerja technical assistance has been forced to focus on the implementation of components of each package, rather than the full package.

USAID's approval of a no-cost extension for Kinerja and Kinerja Papua allows the program to focus on additional capacity building of IOs, further consolidation of its programming in selected treatment districts and to ensure that replication can sufficiently take root and the benefits of Kinerja's proven good practices can be extended to reach even more lives.

6. Monitoring and Evaluation

6.1 M&E Activities Summary

During fiscal year 2014, the Social Impact (SI) Monitoring and Evaluation (M&E) team for Kinerja completed planned activities and routine monitoring. The M&E team welcomed new members during this fiscal year including a new Administrative Assistant, Kinerja Core M&E Specialist, and intern (for the months of July and August 2014). In addition, this fiscal year included the following tasks for the M&E team, each discussed below in more detail: routine monitoring and program support; reporting; and evaluation.

6.2 Routine Monitoring and Program Support

The M&E team supported routine meetings throughout the fiscal year including LPSS meetings (local staff meetings held in each province), Implementing Organization (IO) meetings, national-level Kinerja staff meetings, and national office meetings (as requested). In total, the team attended:

- 14 LPSS meetings (in Aceh, South Sulawesi, West Kalimantan, and East Java);
- 4 IO coordination meetings (in East Java, Aceh, West Kalimantan, and South Sulawesi); and,
- 4 national planning meetings (in Bogor, Jakarta, Bandung, and Bintaro).

During these routine meetings, the M&E team collected data for the current quarter and checked all reported achievement in both one-on-one and group settings (through presentations). The team made presentations at each meeting regarding verified achievements, gaps in reported data by field staff and grantees, indicator definitions, and means of verification.

The M&E team also provided many one-on-one and group training sessions for grantees and RTI Kinerja program staff during this fiscal year. The trainings were mostly held in the Jakarta National Office, during which the M&E team conducted a session on M&E indicators, achievement gaps, and reporting requirements. The team provided training in March 2014 on M&E indicators and requirements for the Kinerja program for new grantees contracted with

RTI in FY14 as well. The team also trained new Short-Term Technical Assistants (STTA) contracted to complete consolidation work in Round 1 district in this fiscal year. The training was also conducted in March 2014.

The M&E Team Leader planned and conducted an M&E workshop on March 28, 2014. The workshop covered three critical topics (listed below) for the Kinerja program as it entered the final quarters of implementation:

1. Kinerja progress against program targets
2. Standard Operating Procedure (SOP) for indicator data collection
3. Performance Management Plan (PMP) revisions based on Kinerja's replication strategy

The Team Leader conducted an additional "refresher" workshop in May 2014 for the District Government partners in the province of West Kalimantan. The districts in West Kalimantan that selected the School Based Management (SBM) intervention are included in Kinerja's rigorous impact evaluation of the SBM program. Considering endline data will be collected starting in Q1 FY15, the Team Leader returned to the district and to Kinerja's partner government officials in this quarter to complete a refresher training on randomized controlled trials, Kinerja's impact evaluation of the SBM intervention, and the schedule for data collection in their districts.

Lastly, the M&E team conducted multiple spot checks of reported achievements during this fiscal year. In Quarter 1, the team spot checked achievements reported from Kota Banda Aceh in Aceh Province (Indicators 5, 6, 7, and 8). In Quarter 2, the team spot checked achievements reported from Kota Singkawang in West Kalimantan Province (Indicators 6, 7, 8, 10, 12, 15, 16, and 17). In Quarter 3, the team spot checked achievements reported from the districts of Probolinggo, Bondowoso, Tulungagung, and Jember in the province of East Java (Indicators 5, 6, 7, 8, 10, 12, 15, 16, and 17). Additionally in Quarter 3, the Team Leader conducted an in-depth spot check of Bengkayang SBM sites in the province of West Kalimantan. During this spot check in May 2014, the Team Leader met with District Education officials to reintroduce the concept of a randomized control trial (as explained above), to explain the status of implementation in West Kalimantan, and to visit partner schools (verifying data for Indicators 6, 7, 8, 10, 12, 15, 16, and 17). In the final quarter of this fiscal year, the Team Leader and M&E intern spot checked district-level progress in the province of South Sulawesi. The team traveled to Bulukumba and Barru and collected and verified data for Indicators 28 – 32.

In addition to field-based spot checks of Kinerja data, Social Impact's Head Quarters staff also conducted a data quality spot check of the Jakarta-based team. This spot check was conducted in April 2014 with no significant findings.

6.2.1 Reporting

In addition to routine reporting requirements including completion of M&E sections for all Quarterly and Annual Reports and Annual Work Plans to USAID, the M&E team completed the following reports/report revisions in this fiscal year: Midterm Evaluation revision, Audit Recommendation report/requirements, and Kinerja's Performance Management Plan (PMP) revision.

In FY14, the M&E Team Leader completed a review and revision of the Midterm Evaluation (MTE) Report, originally submitted in April 2013. USAID, after the audit findings were released in September 2013, requested the M&E team to revisit the MTE, update achievement totals, and re-assess conclusions based on M&E data. The Team Leader, with support from

Social Impact Head Quarters, verified and updated all indicator data and conclusions. SI submitted a revised MTE to USAID on November 11, 2013. The revised report was approved by USAID on January 2, 2014.

The M&E team consolidated improvements made after the USAID Performance Audit in 2013 during this fiscal year. The team strengthened policies and procedures regarding data collection, data verification, grantees and Kinerja staff communication, and data security. The Team Leader submitted final documentation of the M&E system improvements to Kinerja's USAID representatives in January 2014 and in April 2014. As part of the audit follow up from USAID, the M&E team completed requirements for a USAID-led spot check in January 2014 and April 2014. Both spot checks were successfully completed without significant findings regarding data quality or availability. Reports regarding these spot checks were included in final documentation submitted to the USAID audit team.

During Quarter 2 of FY14, the Kinerja program team and district staff clarified the Kinerja replication strategy to ensure it was in-line with the USAID 2013 audit recommendations. The M&E team completed revisions to the PMP in Quarter 2 and proposed these revisions to the program staff during the M&E workshop held in March 2014. The PMP revisions, which were submitted to USAID in July 2014 (Q4 FY14), included updates and revisions to Indicator 5, 8, and 18-27 to ensure that the monitoring plan was in-line with the updated replication strategy. The PMP revision was not approved by USAID (response received in August 2014).

6.2.2 Evaluation

The Kinerja M&E team, during this fiscal year, managed the SBM endline data collection preparation, data collection for the district-level impact evaluation, and management of the SMERU team implementing the qualitative endline data collection. These activities/tasks are detailed below.

In preparation for the SBM endline data collection, the M&E team released a Request for Proposal (RFP) in June 2014 (Q3 FY14). AC Nielsen, a local data collection firm, was selected after a competitive bid process involving two proposal submissions. The firm signed a contract with Social Impact for the endline data collection activity in West Kalimantan in October 2014 (Q1 FY15). The firm will collect data in three partner districts (Bengkayang, Sekadau, and Melawi) during the months of October and November 2014. The firm will aggregate all data in early December and submit a final field report by the end of December.

In preparation for the district-level impact evaluation analysis (to be completed in FY15), the M&E Team Leader requested SUSENAS and RISKESDAS 2013 data from the appropriate government offices. The M&E team purchased SUSENASA data and received the copy in October 2014. As of October 2014, the M&E Team is still waiting for RISKESDAS data.

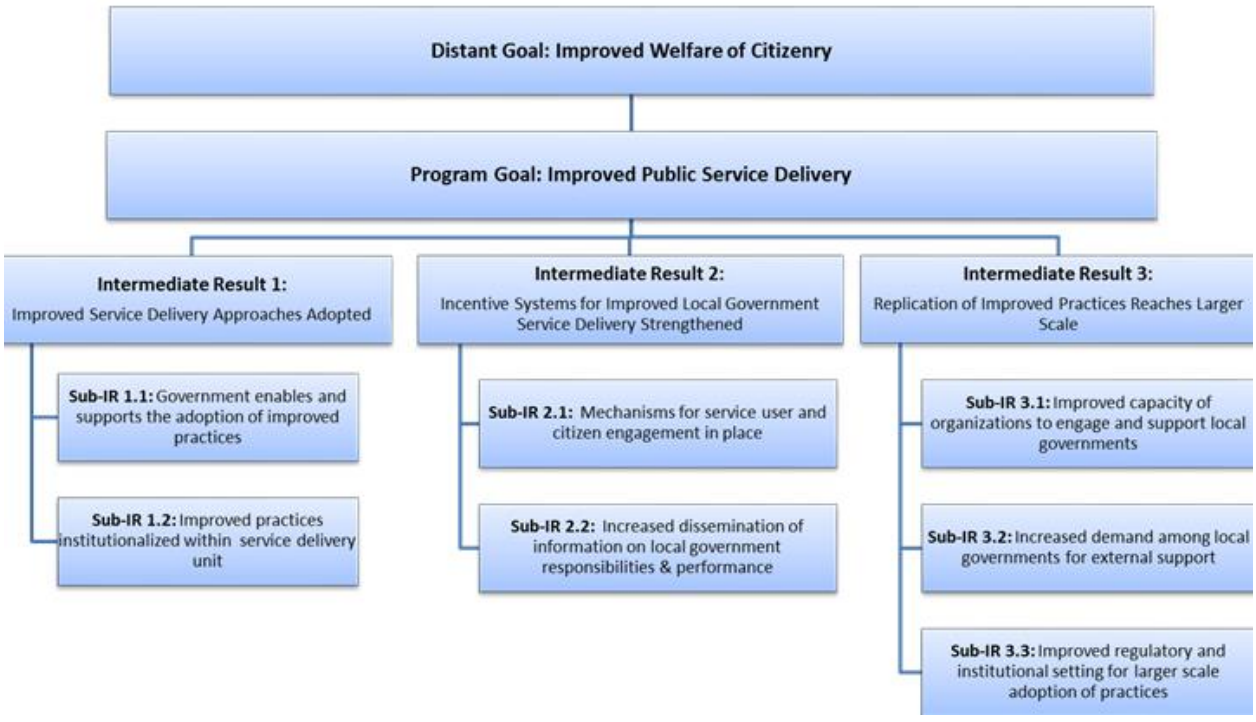
In addition to managing quantitative data collection related to the impact evaluations of the Kinerja program, the M&E team also provided technical input and oversight of Kinerja's subcontractor for qualitative data: SMERU. In Quarter 1, the Team Leader met with the SMERU team to discuss the qualitative endline data collection proposal. The proposal (including sampled districts and a tentative schedule of data collection) was finalized in April 2014 (Q3 FY14) and submitted to USAID. Multiple coordination meetings were held between SI and SMERU in April and May 2014 to prepare for the launch of endline data collection in Bener Meriah. The SI and SMERU team developed and finalized all data collection instruments that were used in the districts for the following interventions during these meetings: Health,

SBM, BOSP, PTD, and BEE. The SI Team Leader wrote five TORs to guide SMERUs work in the field. Additionally, SI and SMERU jointly edited and revised 49 baseline assessment tools covering all interventions. SI also reviewed all inception/methodology reports completed by SMERU before data collection began for each Kinerja intervention.

SMERU collected data in Bener Meriah and Bondowoso in June 2014 (Q3 FY14). The SI Team Leader monitored data collection in Bener Meriah and made slight revisions to several of the data collection instruments before the team moved to Bondowoso. SMERU completed data collection in the following districts during this fiscal year in Quarter 3 and 4: Bener Meriah, Bondowoso, Luwu, Singkawang City, Barru, Banda Aceh City, Probolinggo, Sekadau, Bengkayang, and Bulukumba. SMERU will complete data collection in the final district, Melawi, in Q1 FY15 (October 2014).

6.3 Measuring Kinerja's Achievements

During fiscal year 2014 (FY14), the Kinerja program made progress in the consolidation and replication of Kinerja's interventions in partner and non-partner districts and service delivery units. These efforts led to continued progress in Intermediate Result 1 ("Improved Service Delivery Approaches Adopted"), Intermediate Result 2 ("Incentive Systems for Improved Local Government Service Delivery Strengthened"), and Intermediate Result 3 ("Replication of Improved Practices Reaches Larger Scale"). Progress in these Intermediate Results and their corresponding Sub-Intermediate Results, as detailed in the Kinerja PMP, led to progress in the Program Goal of "Improved Public Service Delivery".



In FY14, the M&E team recorded performance indicator achievements for all 27 performance indicators related to Kinerja's consolidation and replication activities (Indicator 1 – Indicator 27). The program achieved its FY14 targets for 18 of these indicators (67%). Eleven out of 17 performance indicators directly related to the consolidation of Round 1 and Round 2 interventions have achieved or over-achieved FY14 targets (65% of Indicators 1 - 17). Seven out of 10 indicators specifically related to replication have achieved or overachieved FY14

targets (70% of Indicators 18 - 27). Additionally, the Kinerja program has already achieved fourteen program targets during this reporting period for Indicators 1 – 27 (52%).[5] Details about progress in Kinerja's supply, demand, and replication interventions are included below. Additionally, the M&E team has included preliminary analysis of goal-level data received in this fiscal year to explain Kinerja's progress against the Program Goal.

Indicator Type	Indicator Number	PMP Results Framework Location	% Achieved FY14 Target (as of PMP 2012)	% Achieved FY14 Target (USAID Audit recommendation)[6]	% Achieved Program Target (as of PMP 2012)	% Achieved Program Target (USAID Audit Recommendation)
Activity Indicator: ***Round 1 and 2 implementation and consolidation***	1 – 17	Intermediate Result 1 Intermediate Result 2	65%	65%	59%	59%
Activity Indicator: ***Replication***	18 – 27	Intermediate Result 3	70%	80%	40%	50%
Goal Indicator	28 – 38	Program Goal	NA	NA	NA	NA
Impact Indicator	39 – 48	Distant Goal	NA	NA	NA	NA

6.3.1 Consolidation of Round 1 and Round 2

Indicators 1 through 17, detailed below, provide a clear picture of progress for the consolidation of Round 1 and Round 2 interventions in Kinerja's partner districts. Kinerja's interventions include supply and demand side interventions related to work with district government offices, service delivery units, and "beneficiaries" of public services. The consolidation process, which began in FY14, includes continued work with Kinerja's partner units and offices through local implementing organizations and short term technical assistants (STTA). Consolidation progress is documented below in two ways: 1) through the supply and demand perspective; and, 2) through the sector intervention perspective. These perspectives include information from the same indicators but provide a different picture of progress against Kinerja goals.

Supply Side

During FY14, Kinerja partner district governments and service delivery units (SDUs) adopted and formalized improved service delivery models and approaches (Kinerja's supply side intervention). Kinerja partner governments adopted a total of 97 improved service delivery models, ranging from the implementation of standard operating procedures (SOPs) in one-stop-shops (OSS) for business licensing to the calculation of teacher distribution (Indicator 5). These

[5] Explanations of under and over-achievement are included, as necessary, in the Achievement Table for both FY and program targets.

[6] To see further explanation of the achievement against PMP and Audit-recommended targets, please see the Achievement Table.

achievements included a total of 33 new regulations approved and signed by Kinerja's partner district governments.

Kinerja partner SDUs (*puskesmas*, schools, and OSS) institutionalized a total of 436 good practices, including promotion of exclusive breastfeeding in partner *puskesmas* and participatory school planning and budgeting processes in partner schools (Indicator 8). A total of 56 partner *puskesmas* improved or revitalized a complaint handling mechanism (Indicator 10), through which the unit receives feedback and responds to the feedback (most commonly through multi-stakeholder forums' (MSF) review of complaints). Additionally, these partner units submitted a total of 59 technical recommendations to the District Health and Education Offices in Kinerja districts to facilitate improvements based on complaint survey results and/or minimum service standards costing (Indicator 6).

Additionally, Kinerja's partner schools made progress towards the goal of transparency for budgeting and planning information. A total of 114 partner schools published planning documents including annual school plans on information boards and in public areas, ensuring all stakeholders (such as parents or committee members) can access the information (Indicator 15). A total of 134 schools published budgeting documents including the annual school budget (Indicator 16). Lastly, a total of 64 schools published financial report documents in public areas in partner schools (Indicator 17).

Demand Side

To-date, there are 250 MSFs in Kinerja's partner areas at the district and service delivery unit level (Indicator 12). One-hundred and twelve MSFs were documented in FY14 alone as "formed" or "strengthened" by the Kinerja program. During this fiscal year, the MSFs together with Kinerja's partner organizations monitored the implementation of service charters and technical recommendations that resulted from the complaint survey. Indicator 7 tracks the total number of service charters completed by Kinerja's partner units. As of FY14, 237 service charters have been signed by government and community partners. Indicator 11 tracks the percent of complaints/promises from service charters that are implemented or achieved in partner units (180 partner schools and 61 partner *puskesmas*). MSFs and partner organizations submitted complete monitoring forms from 161 units (103 partner schools and 58 partner *puskesmas)*. Of the 4,505 promises made in the monitored service charters, 3,686 were completed/implemented in FY14 (approximately 82%).

Kinerja made progress in advocating for improved public service delivery and reporting on local government performance, as tracked in Indicators 4, 13, and 14. A total of 35 Kinerja-supported implementing organizations conducted advocacy during the Kinerja program (Indicator 4). Five organizations conducted advocacy for the first time in FY14 including media and MSF implementing organizations conducting consolidation activities in partner districts. A total of 32 Kinerja-supported implementing organizations reported on local government performance during the Kinerja program thus far. Many of these organizations participated in Kinerja's Implementing Partner Organization Capacity Building workshops during FY14. The results have been tracked in both Indicator 4 and 13, as organizations have increasingly engaged in demanding public service delivery in Kinerja's partner districts. Kinerja's trained citizen journalists also continued their reporting activities during this fiscal year, exerting pressure on service delivery units and district governments to improve the provision of service delivery. Kinerja's M&E team verified a total of 198 active journalists in FY14 (Indicator 14), achieving almost 100% of the FY target.

The Kinerja program also supported four incentive mechanisms in FY14 (Indicator 9). These achievements include an SBM[7] award in Barru, Autonomy Awards in West Kalimantan and East Java, and a Business Award in Kalimantan. While these mechanisms are meaningful achievements for the program, the indicator remains underachieved. The majority of Kinerja's effort has included supporting partner districts to gain access to incentive mechanisms *already established* at the district, provincial, and international level that they could not otherwise access (considering time, funding, and capacity constraints).

Education

All of the districts that selected the SBM intervention (nine in total) remain challenged by transparency (measured in Indicators 15 – 17). Though Indicators 15 and 16 are overachieved for the fiscal year and annual targets, this is a result of a target that only included half of the Kinerja schools. Of the Round 1 SBM districts, Melawi and Aceh Tenggara[8] are districts that most lack consolidation, though Melawi made advances this quarter in transparency. Kota Probolinggo and Jember are progressing at a slightly quicker rate but still lack full consolidation for the SBM intervention in partner schools. Bengkayang and Sekadau are the strongest districts, according to the performance indicators, from Round 1. Consolidation efforts, however, are still needed in these districts through STTA and Kinerja Technical Specialist oversight in.[9]

From Round 2, Barru and Bener Meriah are progressing well in the SBM intervention. Schools in these districts have achieved transparency and accountability measures in this quarter. Kota Singkawang is progressing but at a slower rate than other Round 2 districts because of initial challenges with the District Education Office. All SBM districts from Round 1 and Round 2 (excluding Aceh Tenggara) require further consolidation and sustainability measures in the coming fiscal year FY15 particularly for transparency and strengthening of school committees.

Kinerja also supports the BOSP[10] and PTD[11] education packages. For the PTD package, Luwu Utara has fully consolidated the intervention according to the performance indicators.[12] This district has passed required regulations for the distribution of teachers and has implemented the distribution of teachers. In this fiscal year, two additional districts (Barru and Sambas) have passed requirements for the distribution of teachers. These districts will require further support in FY15, however, to ensure that implementation of the distribution goes smoothly. Aceh Singkil, Bondowoso, and Luwu require further consolidation to complete the PTD package. These districts have calculated the needs for teachers in their districts but have yet to pass regulations requiring the distribution of teachers in FY15.

[7] School Based Management Intervention

[8] Aceh Tenggara no longer receives Kinerja funding/support due to a lack of interest in the SBM intervention after the district committed to work with the Kinerja program in 2012. Kinerja has not provided additional consolidation support to this district in FY14.

[9] Achievements required in Indicator 6, 7, 8, 15, 16, and 17 for full consolidation of the SBM intervention. When all achievements are completed, the Kinerja program considers the intervention "consolidated".

[10] Educational Unit Operational Cost Analysis intervention

[11] Proportional Teacher Distribution intervention

[12] 2 achievements required in Indicator 5 and one achievement required in Indicator 6 for full consolidation of the PTD intervention. When all achievements are completed, the Kinerja program considers the intervention "consolidated".

For the BOSP package, all three districts have fully consolidated the intervention (Kota Banda Aceh, Simeulue, and Bulukumba) as of this quarter.[13]

Health

Of the 19 Kinerja districts that selected the health package in Round 1 or Round 2, only one has not yet passed a district level regulation about safe delivery and immediate and exclusive breastfeeding (Kota Banda Aceh). Kota Banda Aceh is not expected to pass any new or updated policies regarding maternal and child health because the city already has a Qanun Kibbla[14] regarding these topics. The remaining 18 districts successfully passed updated/revised regulations regarding exclusive breastfeeding, early initiation of breastfeeding, and safe delivery during the Kinerja program. At the *puskesmas*/service delivery unit level, 15 districts have fully consolidated the health intervention.[15] The following districts continue to need sustainability and consolidation support in FY15 to strengthen *puskesmas* management and service provision for pregnant mothers and their children: Kota Banda Aceh, Bondowoso, Melawi, and Kota Singkawang.

Business Enabling Environment (BEE)

All eight districts that selected the BEE package in Round 1 or Round 2 have been successfully consolidated. The focus for the intervention fully shifted to replication in this fiscal year. Achievements regarding the BEE intervention are documented in Indicator 5, 6, 8, 9, 10, and 12.

6.3.2 Replication

Indicators 18 through 27, detailed below, provide an overview of the Kinerja program's progress in replicating good practices in non-partner districts and SDUs. Kinerja's replication intervention includes a supply and demand focus, similar to Round 1 and Round 2 detailed above. The replication strategy includes work with non-partner districts and also intensified work with partner districts and provinces to promote the spread of Kinerja's interventions to new SDUs. Additionally, the strategy includes a focus on the demand side, promoting the establishment of MSFs, citizen journalists, and other advocacy and incentive mechanisms in non-partner areas. The replication strategy began in FY14 and is implemented through Kinerja staff assistance and STTA support, but primarily through government initiative. Replication progress is documented below according to each of the replication indicators.

The Kinerja program expanded to non-partner districts during this fiscal year, spreading Kinerja good practices wider throughout partner provinces. There were 35 non-partner districts (Indicator 19) that adopted a total of 84 Kinerja good practices (Indicator 18) during this fiscal year. Therefore, with the replication of 84 good practices, the Kinerja program has overachieved the FY14 target (420%) and program target (350%) for Indicator 18. Additionally, with a total of 35 non-partner districts, the Kinerja program has overachieved the adjusted FY14 target of 25 districts (140%) for Indicator 19. The new districts that the Kinerja program worked with in FY14 are detailed in the following breakdown:

[13] 2 achievements required in Indicator 5 and one achievement required in Indicator 6 for full consolidation of the BOSP intervention. When all achievements are completed, the Kinerja program considers the intervention "consolidated".

[14] Islamic regulation

[15] Achievements required in Indicator 5, 6, 7, 8, and 10.

Partner Province	Replication District/City (Indicator 19)	Replicated Intervention/Good Practice (Indicator 19)
Aceh	All districts/cities (18 in total): Aceh Barat, Aceh Barat Daya, Aceh Besar, Aceh Jaya, Aceh Selatan, Aceh Tamiang, Aceh Tengah, Aceh Timur, Aceh Utara, Bireuen, Gayo Lues, Kota Langsa, Kota Lhokseumawe, Kota Sabang, Kota Subulussalam, Nagan Raya, Pidie, Pidie Jaya	PPID, MSS, BEE, Health
East Java	3 districts/cities: Pemekasan, Blitar, Trenggalek	BEE
West Kalimantan	2 districts/cities: Kota Pontianak, Kayung Utara	Health, BEE
South Sulawesi	12 districts/cities: Jeneponto, Kota Palopo, Pinrang, Sinjai, Soppeng, Wajo, Bantaeng, Bone, Enrekang, Pangkep, Sidenreng Rappang, Takalar	BEE, Education (BOSP)

Many of these non-partner districts either signed MOUs with Kinerja/Kinerja's grantees or submitted letters of interest regarding technical assistance in replicating good practices in FY14. In this fiscal year, a total of 52 agreements (or "engagements") were documented for Indicator 24. In addition, Indicator 25 notes that over 44% of the agreements finalized during this fiscal year included cost share with district governments. This achievement reveals support for Kinerja partners and interventions in non-partner districts.

In addition to the replication progress made at the district level this fiscal year, significant progress was made at the service delivery unit level as well. Two hundred and three non-partner SDUs in Kinerja's partner provinces adopted Kinerja good practices in this fiscal year.[16] A total of 296 good practices were adopted by these non-partner units during this fiscal year (Indicator 20). These good practices included SBM, service charters, technical recommendations, and maternal and child health promotion (among other good practices).[17] The new SDUs that the Kinerja program worked with in FY14 are detailed in the following breakdown:

[16] The 203 service delivery units include 54 *puskesmas* and 149 schools.
[17] For a full list of good practices available for replication at the service delivery unit, see the PMP 2012.

Partner Province	Replication SDU (Indicator 20)	Replicated Intervention/Good Practice (Indicator 20)
Aceh	Aceh Singkil: 7 *puskesmas* Bener Meriah: 2 *puskesmas*, 10 schools	Health, Education (SBM)
East Java	Kota Probolinggo: 3 *puskesmas*, 99 schools Probolinggo: 10 *puskesmas*	Health, Education (SBM)
West Kalimantan	Kota Singkawang: 1 *puskesmas* Sambas: 12 *puskesmas*	Health
South Sulawesi	Barru: 40 schools Luwu: 9 *puskesmas* Luwu Utara: 10 *puskesmas*	Health, Education (SBM)

Building the capacity of CSOs and Kinerja's grantees for the purpose of long term sustainability and replication is also a focus of the Kinerja program in its final year of implementation. In addition to tracking the number of grantees that are providing technical assistance to non-partner governments in Kinerja provinces, the PMP also notes the number of grantees that develop updated or improved products, services, and marketing strategies for continual use in the promotion of Kinerja good practices. Indicator 21 and 22 note CSOs that have developed products/services or marketing strategies as a result of Kinerja's capacity building. A total of 19 CSOs developed marketing strategies in this fiscal year, clearly outlining their plans to work with and advocate to non-partner district governments toward the improvement of service delivery (Indicator 22). Another 14 districts developed new products or services for the further promotion of service delivery models/approaches (Indicator 21).

Kinerja also made progress in the development of modules that document Kinerja good practices. In this fiscal year, Kinerja's technical team published and made available nine modules containing a total of 15 Kinerja good practices (Indicator 23). The technical team and its affiliated organizations have also developed a total of seven policy papers and policy briefs this fiscal year to influence public policy (Indicator 26).

Finally, there were a total of 27 replication mechanisms documented in Indicator 27 during this fiscal year. These mechanisms, explained in detail in the Achievement Table, represent recurring promotion of Kinerja interventions and good practices at national and provincial levels, ensuring the long term influence of lessons learned through the program.

6.3.3 Goal-Level Progress

Starting in FY14, the M&E team will report on goal-level progress related to the PTD, BOSP, SBM, Health, and BEE intervention. Indicators 28 – 38 relate to the expected outcomes from Kinerja's interventions at the service delivery unit and district level from 2012 – 2015. The data sources for these indicators are largely district health, education, and business licensing offices. Occasionally data will be collected in-person by the M&E team if the district office does not track required data. Lastly, the data source for one indicator is from the national-level SUSENAS dataset. These indicators and progress against FY targets are discussed below according to sector.

Education

Indicators 28 – 32 measure the outcomes of the three Kinerja education interventions (PTD, SBM, and BOSP). Indicators 28 – 30 measure the outcomes of the PTD intervention and are defined below:

- Indicator 28: Percentage of all public schools meeting minimum service standard for availability of teachers
- Indicator 29: Percentage of all public schools meeting minimum service standard for availability of teachers with academic qualifications
- Indicator 30: Percentage of schools meeting minimum service standard for availability of certified teachers

By the end of the PTD intervention, the Kinerja program estimated that these percentages would increase between 2% and 8% depending on district conditions. The targets for each fiscal year and for the program were provided to the M&E team by the Kinerja program team in 2012 during the drafting of the PMP and are included in the Achievement Table (Annex A-2). As of September 2014, complete data regarding these indicators is not yet available from the District Education Office in PTD partner districts. Considering the lack of data and lack of quality data discovered by the M&E team during this fiscal year, it is unlikely that all data will be made available for verification before February 2015. Details regarding available data for each of these indicators are included in the Achievement Table (Annex A-2).

Indicators 31 – 32 measure the outcomes of the SBM intervention and are defined below:

- Indicator 31: Percentage of all public schools meeting minimum service standard for application of principles of school-based management
- Indicator 32: Percentage of KINERJA-supported schools meeting quality standards for availability of basic educational supplies

By the end of the SBM intervention, the Kinerja program estimated that these percentages would increase from the baseline by a percentage dependent on the number of Kinerja-supported or replicated schools divided by the total number of schools in the district. The targets, therefore, vary widely between districts. These targets were also estimated by the Kinerja program team in 2012 depending on local conditions at the baseline. As of September 2014, only a limited amount of data is available from the District Education Office in SBM partner districts. For Indicator 31, the Achievement Table shows some (but not all) fiscal year data from Jember (FY12), Kota Probolinggo (FY12), and Barru (FY14). Though the picture is not yet complete for these districts, these fiscal numbers do show a change in the percentage of public schools meeting MSS for the application of SBM principles. For Indicator 32, the

Achievement Table shows some (but not all) fiscal year data from Bengkayang, Jember, and Kota Probolinggo. Though this picture, also, is not yet complete for these districts, these fiscal numbers do show a change in the percentage of Kinerja-supported schools meeting quality standards regarding basic educational supplies. Considering the lack of data and lack of quality data discovered by the M&E team during this fiscal year, it is unlikely that all data will be made available for verification before February 2015. Further details regarding available data for both of these indicators are included in the Achievement Table (Annex A-2).

Indicator 33 measures the outcome of the BOSP intervention and is defined below:

- Indicator 33
    - Percentage of BOSP (Educational Unit Operational Cost) at primary school level met by national, provincial, or district government sources
    - Percentage of BOSP (Educational Unit Operational Cost) at junior secondary school level met by national, provincial, or district government sources

The Kinerja program team did not develop quantitative targets to measure the change in these percentages/outcomes for the BOSP intervention. In 2012, the program team developed qualitative requirements, included in the Achievement Table (Annex A-2). As of September 2014, the M&E team has verified complete information for Simeulue and Bulukumba. Kota Banda Aceh has not yet made available the required data/information.

Before the Kinerja program, only 52.38% of educational costs for primary school students were met by government funding/sources in Simeulue. This percentage increased during the course of the Kinerja program, reaching 100% met by FY13. In secondary schools, only 68.18% of educational costs were met by government funding/sources in 2010/2011. By FY13, all costs were met by national, provincial, and district sources in Simeulue. This improvement is due in part to the assistance provided through the BOSP intervention in this district. Before the Kinerja program, only 67.71% of educational costs for primary school students were met by government funding/sources in Bulukumba. This percentage increased during the course of the Kinerja program, reaching a high of 96.16% in FY13. A small drop in BOSP was observed in 2014 (to 85.04%). In secondary schools, over 100% of costs were met before the Kinerja program started in Bulukumba. Throughout the program life, the percentage met increased overall to 123.88% by FY14. This improvement is due in part to the assistance provided through the BOSP intervention in this district. Further details regarding available data for both of these indicators are included in the Achievement Table (Annex A-2).

Health

Indicators 34 – 36 measure the outcomes of Kinerja's health intervention in 19 partner districts. These indicators are defined below:

- Indicator 34: Percentage of babies breastfed exclusively
- Indicator 35: Percentage of pregnancies in KINERJA-supported health clinic areas where the mother received antenatal services at least 4 (four) times during pregnancy
- Indicator 36: Percentage of births in KINERJA-supported health clinic areas assisted by qualified healthcare workers

By the end of the health intervention, the Kinerja program estimated that these percentages would increase between 7% and 50% depending on district conditions. The targets for each fiscal year and for the program were provided to the M&E team by the Kinerja program team

in 2012 during the drafting of the PMP and are included in the Achievement Table (Annex A-2). As of September 2014, data is not available for Indicator 34. This data is reported through SUSENAS. The M&E team purchased 2013 SUSENAS data when it became available and received the data in October 2014. The Q1 FY15 report will include actuals for all fiscal years for Indicator 34.

As of September 2014, data has been collected from all partner districts for the health intervention regarding Indicator 35. Data for FY14, however, varies from district to district; districts have reported data ranging from 0 to 7 months for the fiscal year thus far (see Annex A-2). Additional monthly data will be collected by the M&E team in the following quarter to complete the actuals for FY14. Thirty-two percent of the districts that selected the health intervention have seen an increase in the percentage of pregnancies where mothers received antenatal services at least four times during pregnancy as of FY14. These districts include the following: Sambas, Jember, Aceh Tenggara, Jember, Probolinggo, Melawi, and Luwu. These districts improved from their baseline targets as of FY14. [18] Considering data for FY14 is not yet complete, the following additional districts have seen an increase in the percentage of pregnancies where mothers received antenatal services at least four times during pregnancy as of FY13: Bener Meriah, Singkawang City, Probolinggo City, Bengkayang, Bulukumba, Makassar City, and Luwu Utara. Though these increases indicate good progress in these districts, only the following have actually met or exceeded their FY13 targets, included in the Achievement Table (Annex A-2)[19]: Bener Meriah, Sambas, Singkawang City, Jember, Bengkayang, and Luwu Utara.

As of September 2014, data has been collected from all partner districts for the health intervention regarding Indicator 36. Data for FY14, however, varies from district to district; districts have reported data ranging from 0 to 8 months for the fiscal year thus far (see Annex A-2). Additional monthly data will be collected by the M&E team in the following quarter to complete the actuals for FY14.Sixteen percent of the districts (3) that selected the health intervention have seen an increase in the number of births assisted by qualified health workers from the baseline in 2011 to data collection in FY14. These districts include the following: Simeulue, Jember, and Melawi. Considering data for FY14 is not yet complete, the following eight additional districts have seen an increase in this indicator as of FY13: Sambas, Singkawang City, Banda Aceh City, Probolinggo City, Bengkayang, Bulukumba, Makassar City, and Luwu Utara. Though these increases indicate good progress in these districts, only the following have actually met or exceeded their FY13 targets[20]: Sambas, Simeulue, Jember, Makassar City, and Luwu Utara.

When interpreting the increasing and decreasing trends in the Achievement Table for Indicator 35 and 25, it is critical to note the significant changes made in government targets for health outcomes between FY11 and FY12. In FY11 and in previous fiscal years, the government used population data from the 2000 census to calculate targets (for pregnant mothers, for example). In FY12, the government switched to using the 2010 census. This caused a significant change in the population data and, therefore, calculation of targets for pregnant mothers. Any trends identified in the table must be understood according to this adjustment. An analysis of these indicators against program targets will be completed in the final Kinerja report.

[18] This does not include those districts that do not yet have FY14 data.
[19] The districts listed here are those that achieved their FY13 target, as FY14 data is not yet complete.
[20] The districts listed here are those that achieved their FY13 target, as FY14 data is not yet complete.

Business Enabling Environment

Indicators 37 – 38 measure the outcomes of Kinerja's Business Enabling Environment (BEE) intervention in eight partner districts. These indicators are defined below:

- Indicator 37: Number of business permits issued annually
- Indicator 38: Customer Satisfaction Index (CSI) related to business licensing

By the end of the BEE intervention, the Kinerja program (together with The Asia Foundation) estimated that the number of business permits would increase by smaller percentages each year (from a high of 20% to a low of 10%). They also estimated that the CSI would increase in each partner district by 10%. The targets for each fiscal year and for the program were provided to the M&E team by the Kinerja program team and The Asia Foundation in 2012 during the drafting of the PMP and are included in the Achievement Table (Annex A-2).

As of September 2014, data is not available for Indicator 37. This data is reported by The Asia Foundation and will be aggregated for all fiscal years in Q1 FY15. As of September 2014, data has been collected from all partner districts for the BEE intervention regarding Indicator 38 through FY13[21]. Three districts have achieved their FY13 targets: Barru, Melawi, and Luwu Utara. As noted in the Achievement Table (Annex A-2), several districts did not implement the CSI every year, leading to a limited ability to assess trends for the index per district.

6.4 Lessons Learned and Steps Forward

The M&E Team learned valuable lessons in this fiscal year through the data collection, verification, and reporting process. As a result of the first intensive spot checks of reported indicator data, the M&E team committed to writing a one-page Monitoring Memo in order to help the program team assess challenges in the field and plan effective strategies to address them. The M&E Team also developed clear SOPs for data collection regarding activity and replication indicators so that all stakeholders (program staff, grantees, government partners) were clear regarding who would collect data and how it would be processed. The trainings on these SOPs also included re-training on Kinerja's PMP indicators, as it became clear in this fiscal year that many program staff remained confused about the performance indicators and the means of verification for achievements. Lastly, the M&E team created a new grantee report tracking tool to help both the Kinerja program team and the M&E team monitor the progress of grantee monthly reports. The M&E team developed this tool to address the ongoing challenge of collecting grantee reports and providing feedback in a timely manner. This delay had previously caused challenges for the grants team in the processing of grantee milestone payments. Feedback from the Kinerja program team regarding this new tool has been positive.

In fiscal year 2015, the M&E team will continue with routine monitoring and reporting activities. This will include, in particular, collection of goal-level data from partner districts. As mentioned in the M&E Achievements section above, data for these indicators have been difficult to verify. The M&E Specialist will complete data collection in particularly challenging provinces while also conducting the required spot check for each quarter.

The team will also manage AC Nielsen during their collection of SBM endline data in West Kalimantan. The SI M&E team will participate in AC Nielsen's work plan review, enumerator

[21] Data regarding CSI for FY14 are not yet released.

training, and data collection launch in Bengkayang, providing quality oversight. Upon final submission of the endline data, the SI-Jakarta based team and the SI Head Quarters team will analyze SBM baseline and endline data. The final SBM impact evaluation report is scheduled to be completed in February 2015. Additionally, the SI-Jakarta based team will work with the experts at SI Head Quarters to complete the district-level impact evaluation analysis (using SUSENAS and RISKESDAS data). The final district-level impact evaluation report is scheduled to be completed in February 2015.

The M&E team will also continue coordination with SMERU as they collect final data from Bengkayang and begin data aggregation and analysis. The Team Leader will participate in preliminary meetings regarding findings and offer input and recommendations regarding strategies for data aggregation and organization. The SI M&E team will incorporate qualitative findings into the two impact evaluation reports, due in February 2015.

6.5 SMERU: Qualitative Data Collection

6.5.1 Summary

As part of the KINERJA monitoring and evaluation team, SMERU is responsible for qualitatively assessing changes in partner provinces related to the objectives and goals of the program. The qualitative study provides context and in-depth information for the two Kinerja impact evaluations discussed in the quantitative M&E section. The data SMERU collected in 2012 (baseline) and the data collected in 2014 (endline) help answer "why" and "how" questions regarding impact in Kinerja's districts.

6.5.2 Evaluations

First, the SMERU team provided assistance to the Social Impact quantitative M&E team in requesting and collecting SUSENAS and RISKESDAS data from the associated government departments. SMERU also collected secondary data from partner district agencies and service delivery units to help support goal-level data collection for PMP indicators.

Second, SMERU planned for and launched endline qualitative data collection in eleven districts throughout Kinerja's four partner provinces in this fiscal year. The endline data (when compared to baseline data) will be useful to provide a picture of impact in Kinerja districts and other non-quantifiable factors that may have contributed (either positively or negatively) to the implementation and sustainability of the KINERJA program during the last few years.

In preparation for and early implementation of the qualitative data collection effort for endline data, SMERU carried out the following activities in FY14:

- Development of methodology, Terms of Reference (TOR), and research tools
- Selection of 10 districts from baseline and one additional district (to assess the BEE intervention)
- Selection of Regional Researchers (RRs) and arrangement of the research permits
- Implementation of qualitative baseline study; data collection completed in 10 districts as of September 2014

The collection of qualitative data is done through in depth interviews, observations, mini-surveys, and Focus Group Discussions (FGDs). Interviews were conducted with various stakeholders currently involved in the Kinerja program and/or have been present since the beginning of KINERJA program. Qualitative data collection took place at the service delivery

unit level (schools, community health centers, and One-Stop Shops). Data collection also took place in district offices that partner with the Kinerja program. Units/offices in partner and non-partner districts were assessed so that SMERU can better assess the impact Kinerja had in each area.

In each partner district, a maximum of four FGDs were conducted at the service provider unit, community, and multi-stakeholder forum level. Locations for FGDs were decided based on the secondary data collected and through recommendations of the local government officials, Social Impact, LPPS, and/or the KINERJA National Office. SMERU completed a maximum of twenty in-depth interviews in all selected districts to complement the FGD findings. SMERU, in addition to meeting with leaders in SDUs, district health and education offices, and community members, also assessed the role of the Kinerja governance/demand-side interventions in each district by interviewing active citizen journalists, PPID representatives, and/or MSF members.

Five Terms of Reference (TOR) were developed by Social Impact and KINERJA Technical Specialists in Quarter 3 and 4 of FY14. Specifically for the BEE TOR, SMERU and SI coordinated with The Asia Foundation for input and finalization. SMERU and SI then reviewed and edited baseline data collection tools covering all five Kinerja interventions. A total of 49 data collection instruments were finalized for use in data collection in Quarter 3 and 4 of this fiscal year.

There were eleven districts selected for endline data collection by SMERU. The district selection was approved by USAID in Quarter 3 of FY14. These districts were selected based on multiple criteria including intervention selected in year 1 and availability of baseline data. Kabupaten Probolinggo, which received the OSS intervention, is the only district that was not visited by SMERU in the baseline study selected for endline qualitative data collection.

Summary of Districts in Qualitative Baseline, Mid-term, and Endline Data Collection

Kinerja Program	Baseline	Mid-term	End-line
BOSP	Kab. Aceh Tenggara (Aceh) Kab. Bulukumba (South Sulawesi)	Kab. Bulukumba (South Sulawesi)	Kab. Bulukumba (South Sulawesi)
PTD	Kab. Barru (South Sulawesi) Kab. Luwu (South Sulawesi)	Kab. Luwu (South Sulawesi) Kab. Luwu Utara (South Sulawesi)	Kab. Barru (South Sulawesi) Kab. Luwu (South Sulawesi)
SBM	Kab. Bengkayang (West Kalimantan) Kab. Sekadau (West Kalimantan) Kab. Melawi (West Kalimantan)	Kab. Bengkayang (West Kalimantan) Kab. Melawi (West Kalimantan) Kota Probolinggo (East java)	Kab. Bengkayang (West Kalimantan) Kab. Sekadau (West Kalimantan) Kab. Melawi (West Kalimantan)
Health	Kota Banda Aceh (Aceh) Kab. Bener Meriah (Aceh) Kota Singkawang (West Kalimantan) Kab. Bondowoso (East Java)	Kota Banda Aceh (Aceh) Kab. Bener Meriah (Aceh) Kota Singkawang (West Kalimantan) Kab. Bondowoso (East Java)	Kota Banda Aceh (Aceh) Kab. Bener Meriah (Aceh) Kota Singkawang (West Kalimantan) Kab. Bondowoso (East Java)
OSS (BEE)		Kota Tulungagung (East Java) Kota Makassar (South Sulawesi)	Kab. Probolinggo (East Java)[22]
Total	11 districts	12 districts	11 districts

SMERU utilized regional researchers for data collection support in each of the sampled districts. These regional researchers have been working with SMERU for several years. They are both technically qualified and knowledgeable regarding local issues/cultures. Application for the research permits were submitted to the Ministry of Home Affairs (MOHA) in Quarter 3. Based on the approval letter from MOHA, the RRs coordinated the application of the permit at the provincial and district levels in Quarter 3 and 4.

In chronological order, qualitative endline data was collected in Kinerja districts in FY14 as follows:

- Bener Meriah from June 1–9, 2014
- Bondowoso from June 15–23, 2014
- Kota Singkawang and Barru from August 10–18, 2014
- Kota Banda Aceh and Luwu from August 24 – September 1, 2014
- Probolinggo from September 9–17, 2014
- Sekadau and Bengkayang from September 14 –October 1, 2014
- Bulukumba from September 24 – October 2, 2014

[22] TAF and RTI selected this district so that the BEE intervention would be represented in the qualitative endline data collection. Probolinggo was chosen so that the nine districts equally represent each province.

Annex A-1: Kinerja Packages Based on District Consultations

Province	District	Business-Enabling Environment	Education			Health
		One-Stop Shops (OSS) for Business Licensing	Educational Unit Operational Cost Analysis (BOSP)	Proportional Teacher Distribution (PTD)	School-Based Management (SBM)	Immediate and Exclusive Breast Feeding and Safe Delivery
West Kalimantan	Sambas			Second Round		First Round
	Bengkayang				First Round	Second Round
	Sekadau				First Round	Second Round
	Melawi	First and Second Round			First Round	Second Round
	Kota Singkawang				Second Round	First Round
South Sulawesi	Bulukumba		First Round			Second Round
	Barru	First and Second Round		First Round	Second Round	
	Luwu			First Round		Second Round
	Luwu Utara	Second Round		First Round		Second Round
	Kota Makassar	First and Second Round				Second Round
Aceh	Aceh Singkil	First and Second Round		Second Round		First Round
	Aceh Tenggara				First Round	Second Round
	Bener Meriah				Second Round	First Round
	Simeulue	First and Second Round	First Round			Second Round
	Kota Banda Aceh		Second Round			First Round
East Java	Jember				First Round	Second Round
	Tulungagung	First and Second Round				Second Round
	Bondowoso			Second Round		First Round
	Probolinggo	First and Second Round				Second Round
	Kota Probolinggo				First Round	Second Round

Annex A-2: Kinerja Performance Monitoring Plan Achievement[1]

Current Reporting Period: Fiscal Year 2014

NO.	INDICATOR NAME	BASELINE	FY14 TARGET	FY14 ACHIEVEMENT				FY14	PROGRAM TARGET[2]	PROGRAM TO DATE	REMARKS
				Q1	Q2	Q3	Q4				
USAID Governing Justly and Democratically (GJD) Indicators											
1	GJD 2.2.3-3: Number of local mechanisms supported with United States Government (USG) assistance for citizens to engage their subnational government	0	40	78	59	29	69	235 (586%)	613	703 (115%)	There were 69 local mechanisms supported by the Kinerja program that encouraged citizens to engage with their subnational governments. Achievements are disaggregated below by mechanism and include progress made in MSF development, implementation or improvement of complaint handling mechanisms, and formalization of public information offices (PPID): MSF: 26 district, sub-district, or school level Complaint handling mechanism: 15 mechanisms PPID: 1 achievement Local Budget Study: 20 achievements Customer Satisfaction Survey: 7 achievements The Kinerja program has overachieved the FY14 target and has also overachieved the program target for this indicator. *Citizen journalist achievements (as a mechanism for citizen engagement) were counted for 20 districts in Q1 of this FY and are, therefore, not counted again in this quarter as an additional mechanism.*

[1] Final totals are based on the M&E Indicator Database as of October 12, 2014, This table includes verified achievements and information on progress toward achievements in four Kinerja provinces.

[2] The program target and progress against the program target have been included in this quarterly report achievement table, and will be included in each quarterly and annual report achievement table till the end of the Kinerja program. Though progress against the program target will primarily be assessed in the final Kinerja report, the M&E team will provide some comment on this progress in the achievement table.

NO.	INDICATOR NAME	BASELINE	FY14 TARGET	FY14 ACHIEVEMENT				FY14	PROGRAM TARGET[2]	PROGRAM TO DATE	REMARKS
				Q1	Q2	Q3	Q4				
2	GJD 2.2.3-4: Number of local non-governmental and public sector associations supported with USG assistance	0	11	17	7	5	0	29 (263%)	78	78 (100%)	The Kinerja grants team provided information for this indicator, verifying that there were no new grants started during this reporting period. The Kinerja program provided 29 grants during this fiscal year and has provided a total of 78 grants to 37 organizations throughout the life of the program. The program target has been met for this indicator.
3	GJD 2.2.3-5: Number of sub-national entities receiving USG assistance that improve their performance	0	24	13	8	0	1	22 (92%)	24	22 (92%)	Twenty-two partner district or provincial governments have improved their performance by adopting new regulations about service delivery in the sectors of business, education, and health since the beginning of the Kinerja program. The province of South Sulawesi developed an OSS provincial level forum during this quarter. The FY14 and program targets are slightly underachieved as of this quarter. There were non-partner Kinerja districts that improved their performance in this reporting period, but those are noted in Indicator 19.

NO.	INDICATOR NAME	BASELINE	FY14 TARGET	FY14 ACHIEVEMENT				FY14	PROGRAM TARGET[2]	PROGRAM TO DATE	REMARKS
				Q1	Q2	Q3	Q4				
4	GJD 2.4.1-9: Number of civil society organizations (CSOs) receiving USG assistance engaged in advocacy interventions	0	8	0	2	0	3	5 (63%)	63	35 (56%)	All of Kinerja's grantees conducted advocacy in this reporting period. A total of 35 grantees (from Kinerja's 37 current grantees) have conducted advocacy during the Kinerja program. Three additional grantees were documented as conducting advocacy in this quarter, including LPS Air, Puskakom, and Sepakat. MSFs supported by the Kinerja program also play an important role in advocating for improvements in public service delivery in Kinerja partner districts and service delivery units. Though these MSFs are not counted as CSOs, as tracked by this indicator, they should be noted here for their contribution to advocating for Kinerja issues. Kinerja currently has 250 MSFs documented that have conducted advocacy (either at the service delivery unit or district level). The FY14 and program target are currently underachieved because this indicator target was based on an estimated number of Kinerja grantees in 2012. Considering Kinerja's work with 37 grantees to-date, this indicator will remain underachieved for the duration of the program.
Activity Indicators											

NO.	INDICATOR NAME	BASELINE	FY14 TARGET	FY14 ACHIEVEMENT				FY14	PROGRAM TARGET[2]	PROGRAM TO DATE	REMARKS
				Q1	Q2	Q3	Q4				
5	Number of times Kinerja-supported improved service delivery models or approaches are adopted by local governments	0	75	28	37	13	19	97 (129%)	191	179 (94%)	Kinerja partner districts adopted a total of nineteen improved service delivery models in this reporting period. Throughout this fiscal year, Kinerja's 20 partner districts have adopted 97 good practices (ranging from the establishment of MSFs to the formal adoption of improved policies and regulations). These 97 achievements include a total of 33 new regulations signed by Kinerja's partner district governments. The fiscal year target for FY14 has been overachieved. Throughout the Kinerja program, Kinerja's 20 partner districts have adopted 179 good practices. Regulations collected and/or signed in this reporting period (July – September) are disaggregated below by sector: • BEE: 7 achievements • Education: 3 achievements • Minimum Service Standards: 8 achievements • PPID: 1 achievement *For a list of Kinerja models/approaches at the district level, refer to the PMP 2012.*
6	Number of Kinerja-supported technical recommendations to the District Technical Working Unit (SKPD), DPRD, district head Bupati that have involved or are formally endorsed by other non-government actors	0	14	13	13	4	29	59 (421%)	69	246 (357%)	Twenty-nine technical recommendations were signed and submitted to government departments in Kinerja districts in this reporting period. The Kinerja program overachieved the fiscal year target for FY14 and also has overachieved the program target. The technical recommendations collected and/or signed in this reporting period are disaggregated below by sector: • Education: 29 achievements from Kota Singkawang and Melawi The program target for technical recommendations has been overachieved because the Kinerja program only targeted technical recommendations at the district level. The strategy implemented in the field, however, required technical recommendations from service delivery units as a result of the complaint survey process, BOSP calculation, or PTD calculation. For this reason, the program target is overachieved.

NO.	INDICATOR NAME	BASELINE	FY14 TARGET	FY14 ACHIEVEMENT				FY14	PROGRAM TARGET[2]	PROGRAM TO DATE	REMARKS
				Q1	Q2	Q3	Q4				
7	Number of service charters agreed upon with Kinerja support	0	21	6	3	0	0	9 (43%)	237	237 (100%)	The Kinerja program has achieved the program target for Indicator 7, with 237 service charters signed and formalized as a result of the complaint survey process. Kinerja over-achieved the FY13 target and, therefore, has underachieved the FY14 target (as noted here at 43%).
8	Number of times Kinerja-supported improved practices for service delivery are institutionalized by service delivery units	0	84	115	158	77	86	436 (519%)	782	785 (100%)	Kinerja's partner schools and *puskesmas* institutionalized many Kinerja good practices during this reporting period, ranging from Breastfeeding Education to promoting a transparent and participatory school budgeting and planning process. Kinerja has overachieved the FY14 target and also has achieved the program target (100%). Practices institutionalized and/or collected in this reporting period are disaggregated below by sector: Health: 53 practices institutionalized Education: 28 practices institutionalized (including school committees) Governance: 5 practices institutionalized (*puskesmas* -level MSFs) *For a list of Kinerja improved practices at the service delivery unit level, refer to the PMP 2012.*

NO.	INDICATOR NAME	BASELINE	FY14 TARGET	FY14 ACHIEVEMENT				FY14	PROGRAM TARGET[2]	PROGRAM TO DATE	REMARKS
				Q1	Q2	Q3	Q4				
9	Number of Kinerja-supported mechanisms that incentivize district government or service delivery units based on actual performance	0	15	3	0	1	0	4 (27%)	38	14 (37%)	There were no incentive mechanisms developed during this quarter. The Kinerja program has underachieved the FY14 target. This indicator is underachieved against the fiscal year and program target because the Kinerja approach regarding incentive mechanisms utilized existing incentive mechanisms in each of the Kinerja provinces instead of supporting unique Kinerja mechanisms. While some incentive mechanisms were promoted by Kinerja's partners (to date, 14) at the provincial level, the majority of Kinerja's effort included supporting partner districts to gain access to incentive mechanisms at the district, provincial, national, and international level that they could not otherwise access (considering time, funding, and capacity constraints). Considering the specific definition of this indicator, these achievements were not reported against the target of 38. For this reason, the Kinerja program will underachieve for Indicator 9.
10	Number of Kinerja-supported feedback mechanisms at the district government- or service-delivery unit levels used by clients and users	0	16	10	17	14	15	56 (350%)	66	75 (136%)	Achievements noted in this reporting period for Indicator 10 included complaint boxes, SMS gateways, and SOPs regarding the handling of complaints in Kinerja supported *puskesmas*. Most of these verified achievements were accomplished in previous quarters but were without sufficient supporting evidence. The M&E team received sufficient supporting evidence for these achievements in this quarter and, therefore, counted 15 new achievements for Kinerja's partner *puskesmas*. The Kinerja program has overachieved the FY14 target and the program target for this indicator.
11	Percentage of complaints about services received through Kinerja-supported complaint survey process, which is addressed by public service delivery units	0	70%	0	0	81%	82%	82% (117%)	70%	n/a	Kinerja grantees supported the MSFs in their monitoring activities of service charters in this quarter. During the quarter, MSFs monitored service charter implementation in schools and *puskesmas*. In this fiscal year, 161 completed monitoring forms were submitted by partner organizations and/or partner MSFs. Of the 4,505 promises made in service charters from the 103 schools and 58 *puskesmas*, 3,686 were completed/implemented (approximately 82%). Progress against the program target will be measured at the end of the program when all the monitoring forms for 237 units are

NO.	INDICATOR NAME	BASELINE	FY14 TARGET	FY14 ACHIEVEMENT				FY14	PROGRAM TARGET[2]	PROGRAM TO DATE	REMARKS
				Q1	Q2	Q3	Q4				
											submitted and verified. The fiscal year target for FY14, however, has been achieved.
12	Number of Kinerja-supported linkages between CSOs, users, DPRD, Dinas, and others, which are active in the oversight of service delivery	0	17	38	33	15	26	112 (659%)	270	250 (93%)	There are currently 250 formed and active MSFs in the Kinerja program. MSF activities range from advocating for policy improvements in district health and education offices to monitoring complaint surveys and service charter implementation at the service delivery unit level. While the FY14 target is overachieved (due to underachievement in previous FY), the program target is underachieved as of this quarter. An additional 26 MSFs were documented in this quarter. The newly formed MSFs noted in this reporting period are MSFs that have been operating in previous quarters but had not yet submitted formal documentation of their structure and schedule. The MSFs counted in this quarter are included below, disaggregated by type: School committees: 17 formed/strengthened MSF *puskesmas*/kecamatan level: 6 formed/strengthened MSF district level: 3 formed/strengthened (1 health, 2 education)
13	Number of non-media CSOs that report on local government performance	0	23	24	26	27	32	32 (139%)	23	32 (139%)	Kinerja's initial support of implementing organizations did not emphasize building the capacity of non-media CSOs to report on local government performance. It focused more on capacity building regarding advocacy and change promotion. The program increased this focus, however, through the work of the Capacity Building Task Force and through mentoring provided by Kinerja's district and provincial level staff in FY14. There were five grantees in this quarter that reported on local government performance: Jurnal Celebas, KIPPAS, JPIP, LPS Air, and Puskakom. *This indicator was initially targeted for MSFs in the Kinerja PMP. MSFs, however, have just now started gaining strength and organization in Kinerja's consolidation phase. For this reason, Kinerja implementing organizations have done the majority of the reporting on local government performance during the Kinerja program and are documented here.*

NO.	INDICATOR NAME	BASELINE	FY14 TARGET	FY14 ACHIEVEMENT				FY14	PROGRAM TARGET[2]	PROGRAM TO DATE	REMARKS
				Q1	Q2	Q3	Q4				
14	Number of Kinerja-supported citizen journalists actively reporting on local government performance	0	200	76	38	67	119	198 (99%)	200	246 (123%)	A total of 119 citizen journalists remained active from July through September 2014, reporting through 282 articles on local government performance and also voicing opinions and concerns about service delivery issues in their respective areas. The Kinerja program has slightly underachieved the fiscal year target but has overachieved the program target as of September 2014. The fiscal year total reports the total number of citizen journalists that were active in at least one quarter of the fiscal year (198 journalists). Journalists active in multiple quarters are not recorded twice against the annual target. The program target reports the total number of citizen journalists that were active in at least one quarter of the entire Kinerja program (246 journalists). As with the annual target, journalists active in multiple quarters are not recorded twice against the program target. Citizen journalists for this quarter (and number of articles produced) are disaggregated below by province: • West Kalimantan: 44 citizen journalists, 140 articles/publications • South Sulawesi: 31 citizen journalists, 72 articles/publications • East Java: 23 citizen journalists, 36 articles/publications • Aceh: 21 citizen journalists, 34 articles/publications
15	Number of Kinerja-supported service delivery units where key planning documents are made available to stakeholders	2	92	103	108	112	114	114 (124%)	92	114 (124%)	School planning documents have been made public through school committee meetings, planning meetings involving the community and other stakeholders, and through published documents on Kinerja partner school walls/public areas. There were two additional planning documents documented as "published" during this reporting period. The total number of planning documents to-date that have been "made available for stakeholders" is 114. This indicator has overachieved the FY14 and program target.
16	Number of Kinerja-supported service delivery units where key budgeting documents are made available to stakeholders	3	93	104	110	127	134	134 (144%)	93	134 (144%)	School budget documents have been made public through school committee meetings, budgeting meetings involving the community and other stakeholders, and through published documents on Kinerja partner school walls/public areas. There were 7 additional budgeting documents verified as "published" during this reporting period. The total number of budgeting documents to-date that has

NO.	INDICATOR NAME	BASELINE	FY14 TARGET	FY14 ACHIEVEMENT				FY14	PROGRAM TARGET[2]	PROGRAM TO DATE	REMARKS
				Q1	Q2	Q3	Q4				
											been "made available for stakeholders" is 134. This indicator has overachieved the FY14 and program target.
17	Number of Kinerja-supported service delivery units where key financial reporting documents are made available to stakeholders	5	95	7	17	39	64	64 (67%)	95	64 (67%)	In this reporting period, Kinerja partners submitted sufficient documentation for an additional 25 schools. These schools have published or made available for stakeholders their financial reports. Achievements for this indicator were low in previous fiscal years because the Kinerja program did not emphasize transparency of financial reporting documents in the SBM intervention. Considering this focus was only introduced during consolidation, this indicator will be underachieved.
Replication Indicators											
18	Number of times Kinerja-supported good practices are adopted by local governments outside of the original Kinerja target jurisdictions	0	20	7	2	39	36	84 (420%)	24	84 (350%)	Kinerja good practices were adopted 36 times by districts outside Kinerja's partner districts in this reporting period. These good practices included the same good practices that Kinerja's partner service delivery units adopted during Round 1 and Round 2 of Kinerja implementation (tracked in Indicator 5 or 8). The Kinerja program has overachieved the FY14 and program target for this indicator. Good practices achieved in this quarter are detailed below disaggregated by province: • Aceh: 18 achievements including replication of health and BEE good practices • East Java: 2 achievements related to the replication of BEE good practices • West Kalimantan: 2 achievements related to the replication of BEE good practices • South Sulawesi: 14 achievements including the replication of education (BOSP) and BEE good practices

NO.	INDICATOR NAME	BASELINE	FY14 TARGET	FY14 ACHIEVEMENT				FY14	PROGRAM TARGET[2]	PROGRAM TO DATE	REMARKS
				Q1	Q2	Q3	Q4				
19	Number of non-Kinerja-supported districts where adoption of Kinerja-supported good practices take place	0	50	5	1	18	11	35 (70%)	50	35 (70%)	A total of 35 non-partner districts have replicated Kinerja good practices as of September 2014. The Kinerja program has underachieved the fiscal year target and remains underachieved for the program target. The program target of 50, however, reflects the initial replication strategy (2012) and not the adjusted strategy approved by USAID in 2013. The adjusted strategy targets 25 districts for replication. According to the adjusted target, the Kinerja program has overachieved for this fiscal year and for the program. These districts are detailed below by province: • Aceh: 18 districts (Aceh Barat, Aceh Barat Daya, Aceh Besar, Aceh Jaya, Aceh Selatan, Aceh Tamiang, Aceh Tengah, Aceh Timur, Aceh Utara, Bireuen, Gayo Lues, Kota Langsa, Kota Lhokseumawe, Kota Sabang, Kota Subulussalam, Nagan Raya, Pidie, Pidie Jaya) • East Java: 3 districts (Pemekasan, Blitar, Trenggalek) • West Kalimantan: 2 districts (Kota Pontianak, Kayung Utara) • South Sulawesi: 12 districts (Jeneponto, Kota Palopo, Pinrang, Sinjai, Soppeng, Wajo, Bantaeng, Bone, Enrekang, Pangkep, Sidenreng Rappang, Takalar) There were 11 new districts in this quarter that replicated good practices. The new districts that adopted a Kinerja good practice are detailed below by province for this quarter: • East Java: Kab. Blitar, Trenggalek (BEE) (2 districts) • West Kalimantan: Kayung Utara (BEE) (1 district) • South Sulawesi: Jeneponto, Kota Palopo, and Sidenreng Rappang (BOSP); Bantaeng, Bone, Enrekang,, Pangkep, and Takalar (BEE) (8 districts)

NO.	INDICATOR NAME	BASELINE	FY14 TARGET	FY14 ACHIEVEMENT				FY14	PROGRAM TARGET[2]	PROGRAM TO DATE	REMARKS
				Q1	Q2	Q3	Q4				
20	Number of times Kinerja-supported improved practices for service delivery are institutionalized by service-delivery units not receiving direct implementation support	0	344	16	164	0	116	296 (86%)	344	296 (86%)	During this reporting period, Kinerja made significant progress toward internal replication achievements. The program replicated Kinerja good practices 116 times in non-partner units (schools and *puskesmas*). The program did not achieve the FY14 target and remains slightly underachieved for the program target. Progress made in this quarter is detailed below: • SBM: 10 replication of Kinerja good practices in non-partner schools • Health: 106 replication of Kinerja good practices in non-partner *puskesmas* Regarding the total number of units that adopted these good practices during this fiscal year, the details are included below: • Number of non-partner schools that have adopted good practices: 149 • Number of non-partner puskesmas that have adopted good practices: 54
21	Number of Kinerja-affiliated Indonesian CSOs that have developed new or updated products or services for local governments	0	5	6	6	0	2	14 (280%)	61	14 (23%)	During this reporting period, Kinerja's Capacity Building Task Force conducted capacity building and training. Two additional organizations developed new or updated products or services for local governments including Madanika and Bitra (BEE). After USAID approved of Kinerja's replication strategy in 2013, the target of 61 was proposed as 21. Phase 1 organizations are not targeted here, as they were not engaged in the capacity building task force activities in FY14. There were 21 local grantees selected to attend the capacity building workshops. Kinerja expects to achieve 21 for this indicator by the end of the program. For this reason, the program target will remain underachieved, though Kinerja has achieved the FY14 target.

NO.	INDICATOR NAME	BASELINE	FY14 TARGET	FY14 ACHIEVEMENT				FY14	PROGRAM TARGET[2]	PROGRAM TO DATE	REMARKS
				Q1	Q2	Q3	Q4				
22	Number of Kinerja-affiliated Indonesian CSOs that have marketing or outreach strategies targeting local government	1	12	4	2	9	4	19 (158%)	24	19 (79%)	During this reporting period, Kinerja's Capacity Building Task Force focused on implementing capacity building and training for Kinerja's partner organizations. Four additional organizations developed marketing and outreach strategies targeting local governments in this quarter: LPKP, Yapikma, JPIP, and Bitra. The Kinerja program has achieved the FY14 target but remains underachieved for the program target. After USAID approved of Kinerja's replication strategy in 2013, the target of 24 was proposed as 21. Phase 1 organizations are not targeted here, as they were not engaged in the capacity building task force activities in FY14. There were 21 local grantees selected to attend the capacity building workshops. Kinerja expects to achieve 21 for this indicator by the end of the program. For this reason, the program target may remain underachieved.
23	Number of Kinerja-supported good practices that are contained in replication packages available for use by Indonesian CSOs	0	28	0	7	4	4	15 (55%)	28	15 (55%)	During this reporting period, Kinerja's technical team finalized, published, and made available to partner organizations 3 modules about Kinerja's packages (Health and Minimum Service Standards). These modules include 4 Kinerja good practices. The modules finalized in this quarter are listed below: • Tata Kelola Persalinan Aman • Tata Kelola Inisiasi Menyusu Dini Dan ASI Eksklusif • Metode Dan Teknik Advokasi Dan Pengawasan Peningkatan Mutu Pelayanan Publik Berbasis Standar Pelayanan In total, the Kinerja program has finalized 9 modules that contain 15 good practices. After USAID approved of Kinerja's replication strategy in 2013, the program target of 28 was proposed as 24. Kinerja's current strategy includes the formation of 17 modules that will include 24 good practices. For this reason, the FY14 target was not met, and the program target will remain underachieved.

NO.	INDICATOR NAME	BASELINE	FY14 TARGET	FY14 ACHIEVEMENT				FY14	PROGRAM TARGET[2]	PROGRAM TO DATE	REMARKS
				Q1	Q2	Q3	Q4				
24	Number of engagements in which Kinerja-affiliated Indonesian organizations provide technical assistance or other support for Kinerja-supported products to districts outside of the original target jurisdiction	0	20	19	8	18	7	52 (260%)	24	52 (216%)	During this reporting period, Kinerja's grantees forged formal partnerships with district governments to support the replication of good practices. These formal engagements between civil society and the government represent an avenue through which replication can occur and sustainability can be ensured. An additional 7 engagements were noted during this quarter. These agreements include the following districts, disaggregated by Kinerja province: • Aceh: 3 engagements regarding health • East Java: 1 engagement regarding health • South Sulawesi: 1 engagement regarding BEE • West Kalimantan: 2 engagements, 1 regarding health and 1 regarding BEE This replication indicator has overachieved the FY14 target and has already overachieved the program target (216%). Kinerja did not originally target many formal relationships because district governments are usually not eager to formally engage with CSOs. This overachievement shows the respect for and capacity of Kinerja's grantees in partner districts and also the willingness of district governments to contract assistance from civil society and Kinerja partners.
25	Number of engagements in which local governments or service-delivery units contribute to cost of technical assistance by Kinerja-affiliated Indonesian CSOs	0	10	5	3	11	4	23 (230%)	12	23 (192%)	Forty-four percent of the engagements noted above in Indicator 24 included cost share specifications with the district government (or government entities). There were 4 new engagements documented in this quarter that included specific local government contribution to good practice implementation. Engagements counted in this reporting period include the following: • Aceh: Gayo Lues (health) • West Kalimantan: Kubu Raya (health) and Sambas (BEE) • South Sulawesi: Luwu (BEE) The Kinerja program has overachieved the FY14 target and has also already overachieved the program target (192%). This overachievement shows the willingness of district governments to contract assistance from civil society and Kinerja partners and contribute to the cost of implementation of improved service delivery models.

NO.	INDICATOR NAME	BASELINE	FY14 TARGET	FY14 ACHIEVEMENT				FY14	PROGRAM TARGET[2]	PROGRAM TO DATE	REMARKS
				Q1	Q2	Q3	Q4				
26	Number of policy papers published that are directed at the provincial or national level to support replication of good practices in local service delivery	0	2	2	2	1	2	7 (350%)	6	7 (117%)	Kinerja and Kinerja affiliated organizations have developed policy papers and policy briefs to contribute to national, provincial, and district level policy improvements in health, education, and business. This quarter, the M&E team noted two new achievements: • Kinerja contribution/input regarding revision of Peraturan Kepala LAN No 10 Tahun 2011 • SMERU policy paper on Minimum Service Standards The Kinerja program has overachieved the FY14 target and has already overachieved the program target for this indicator.
27	Number of mechanisms to support the adoption of good practices related to Kinerja activities	0	21	13	5	4	5	27 (129%)	31	27 (87%)	Kinerja's replication efforts at the provincial and national level continued during this reporting period. There were 5 new mechanisms counted in this quarter, including the following: • BEE replication workshops in Aceh, West Kalimantan, and at the national level (3 achievements) • Incorporation of Kinerja's Minimum Service Standards good practice into the LAN curriculum (1 achievement) • JPIP's autonomy award research (Studi Keberlanjutan Inovasi Dan Praktik Baik Pemerintah Kab/Kota Peraih Otonomi Award Di Jawa Timur) (1 achievement) The Kinerja program has overachieved the FY14 target and is only slightly underachieved the program target for this indicator.

Annex A-3: List of Local Regulations Passed in FY 2014

This list of regulations includes those passed in Kinerja's partner districts and those passed in Kinerja's replication districts during the 2014 fiscal year. Achievements in *italics* are from replication districts.

> **regulations are reported in the quarter they were received by the M&E team (not necessarily the quarter in which they were signed) in order to ensure data quality and verification standards*
>
> ***regulations that count as more than one achievement for an intervention cover one or more of Kinerja's service delivery models. See PMP definitions for more details*

Aceh

1. Perbup Aceh Singkil No 18 2013, Pelayanan Perizinan Secara Paralel pada Kantor Pelayanan Perizinan Terpadu Satu Pintu (1 achievement BEE)
2. Perbup Aceh Singkil No 26 2013, Penyederhanaan Perizinan Usaha Pada Kantor Pelayanan Perizinan Terpadu Satu Pintu (1 achievement BEE)
3. Perbup Aceh Tenggara No 26 2014, Persalinan Aman, Inisiasi Menyusu Dini, dan Pemberian ASI Eksklusif (3 achievements Health)
4. Perbup Simeulue No 24 2013, Perubahan atas Peraturan Bupati Simeulue No 2/2012 tentang Pelimpahan Kewenangan Perizinan dan Non Perizinan kepada Kantor Pelayanan Perizinan Terpadu (1 achievement BEE)
5. Perbup Simeulue No 12 2014, Dana Penjungang Pendidikan Berkeadilan (1 achievement Education)
6. *Keputusan Kepala Kantor Pelayanan Perizinan Terpadu Kapbupaten Aceh Jaya No 954/14/2014 (1 achievement BEE)*
7. *Peraturan Bupati Aceh Jaya No 32 Tahun 2013 Tentang Pedoman Pengelolaan Informsi Dan Dokumentasi Di Lingkungan Pemerintah Kab Aceh Jaya (1 achievement PPID)*
8. *Peraturan Bupati Aceh Jaya No 32 Tahun 2014 Tentang Pelimpahan Kewenangan Penandatanganan Perizinan (1 achievement BEE)*
9. *Peraturan Bupati Aceh Tengah Nomor 24 Tahun 2013 Tentang Pedoman Pengelolaan Pelayanan Informasi dan Dokumentasi di Lingkungan Pemerintah Kabupaten Aceh Tengah (1 achievement PPID)*
10. *Peraturan Bupati Aceh Selatan Nomor 22 Tahun 2014 Tentang Pelimpahan Kewenangan di Bidang Perizinan dan Non Perizinan Kepada Kantor Pelayanan Perizinan Terpadu Kabupaten Aceh Selatan (2 achievements BEE)*
11. *Keputusan Bupati Aceh Selatan Nomor 247 Tahun 2014 Tentang Penetapan Standar Operasional Prosedur Pada Kantor Pelayanan Perizinan Terpadu Kabupaten Aceh Selatan (1 achievement BEE)*
12. *Keputusan Bupati Aceh Selatan Nomor 230 Tahun 2014 Tentang Pembentukan Tim Teknis Kantor Pelayanan Perizinan Terpadu Kabupaten Aceh Selatan (1 achievement BEE)*

13. *Keputusan Bupati Gayo Lues Nomor 065/SK/2014 Tentang Pembentukan Tim Teknis Peningkatan Kualitas Pelayanan Kesehatan Ibu dan Anak Dan Layanan Pendidikan Dasar Kabupaten Gayo Lues Tahun 2014 (1 achievement Health and Education)*
14. *Peraturan Bupati Pidie Jaya Nomor 22 Tahun 2013 Tentang Standar Operasional Prosedur (SOP) Pada Kantor Pelayanan Perizinan Terpadu Satu Pintu (KP2TSP) Kabupaten Pidie Jaya (1 achievement BEE)*
15. *Peraturan Walikota Subulussalam Nomor 14 Tahun 2014 Tentang Standar Operasional Prosedur (SOP) Pelayanan Perizinan dan Pengaduan Pada Kantor Pelayanan Perizinan Terpadu Kota Subulussalam (3 achievements BEE)*

East Java

1. Perbup Kab Probolinggo No 47 2013, Pelimpahan Kewenangan (1 achievement BEE)
2. Perbup Kab Probolinggo No 23 2013, Pendoman Pengelolaan Informasi dan Dokumentasi di Lingkungan Pemerintah Kab Probolinggo (1 achievement PPID)
3. Perbup Tulungagung No 22 2013, Pelaksanaan Pelyanan Perizinan Sistem Paket (1 achievement BEE)
4. Perbup Bondowoso No 60 2013, Pedoman Penataan Dan Pemerataan Guru Pegawai Negeri Sipil Di Lingkungan Pemerintah Kabupaten Bondowoso (1 achievement Education)
5. Perbup Bondowoso No 47 2013, Pedoman Pengelolaan Informasi Dan Dokumentasi Di Lingkungan Pemerintah Kab Bondowoso (1 achievement PPID)
6. *Keputusan Kepala Kantor Pelayanan Terpadu Satu Pintu Kabupaten Blitar Nomor 188/04/409.303/KPTS/2014 Tentang Standar Pelayanan Pengaduan Perijinan Pada Kantor Pelayanan Terpadu Satu Pintu (KPTSP)Kabupaten Blitar (1 achievement BEE)*
7. *Peraturan Bupati Trenggalek Nomor 27 Tahun 2014 Tentang Pelimpahan Wewenang Penyelenggaraan Perizinan Dan Nonperizinan Kepada Kantor Perizinan dan Penanaman Modal (1 achievement BEE)*

West Kalimantan

1. Perbup Melawi No 28 2013, Pelimpahan Kewenangan di Bidang Perizinan dan Nonperizinan Kepada Kepala Badan Pelayanan Terpadu Dan Penanaman Modal Daerah Kab Melawi (1 achievement BEE)
2. Perda Melawi No 7 2013, Retribusi Izin Usaha Jasa Konstruksi, Retribusi Pelayanan Kesehatan Pada Pusat Kesehatan Masyarakat, Retribusi Tanda Daftar Perusahaan, Retribusi Izin Usaha Perdagangan, Penerimaan Sumbangan Pihak Ketiga Dan Retribusi Izin Usaha Industri (1 achievement BEE)
3. Perbup Melawi No 40 2013, Persalinan Aman, Inisiasi Menyusu Dini, dan Pemberian ASI Eksklusif (3 achievements Health)
4. SK Bupati Melawi No 550-19 2013, Pembentukan Pejabat Pengelola Informasi dan Dokumentasi di Lingkungan Pemerintah Kab Melawi (1 achievement PPID)
5. Perbup Sambas No 5 2014, Pedoman Pelaksanaan Distribusi Guru Pegawai Negeri Sipil Secara Proporsional (1 achievement Education)
6. Perbup Sekadau No 33 2013, Persalinan Aman, Inisiasi Menyusu Dini, dan Pemberian ASI Eksklusif (3 achievements Health)

7. Perbup Bengkayang No 6 2014, Persalinan Aman, Inisiasi Menyusu Dini dan Air Susu Ibu Eksklusif (3 achievements Health)
8. Perbup Bengkayang No 33 2013, Standar Prosedur Operasional Pelayanan Informasi Publik di Lingkungan Pemerintah (1 achievement PPID)
9. Peraturan Bupati Sambas Nomor 19 Tahun 2014 Tentang Pelayanan Perizinan Dan Non Perizinan Terpadu (1 achievement BEE)
10. Peraturan Bupati Sekadau No 23 Tahun 2014 Tentang Standar Pelayanan Minimal Bidang Pendidikan Dasar Kabupaten Sekadau (1 achievement MSS)
11. Keputusan Bupati Sambas Nomor 547/Disdik/2014 tentang Petunjuk Teknis Pelaksanaan Peraturan Bypati Sambas No 5 Tahun 2014 tentang Pedoman Pelaksanaan Distribusi Guru Pegawai Negeri Sipil Secara Proporsional (1 achievement Education)
12. *Keputusan Bupati Kayong Utara Nomor 344/KPPTSP/VIII/2014 Tentang Standar Operasional Prosedur Pelayanan Perizinan Terpadu Satu Pintu Pada Kantor Pelayanan Perizinan Terpadu Satu Pintu (1 achievement BEE)*
13. *Keputusan Bupati Kayong Utara Nomor 253/KPPTSP/V/2014 Tentang Pembentukan Tim Teknis Perizinan Kantor Pelayanan Perizinan Terpadu Satu Pintu Kabupaten Kayong Utara (1 achievement BEE)*

South Sulawesi

1. Perbup Bulukumba No 8 2013, Standar Layanan Informasi Publik Lingkup Pemerintah Kab Bulukumba (1 achievement PPID)
2. Perda Kota Makassar No 7 2013, Perubahan Kedua Atas Peraturan Daerah Nomor 3 Tahun 2009 Tentang Pembentukan Dan Susunan Organisasi Perangkat Daerah Kota Makassar (1 achievement BEE)
3. Perwali Makassar No 101 2013, Penerapan Standar Pelayanan Minimal (SPM) Bidang Kesehatan Kota Makassar (1 achievement MSS)
4. Perwali Makassar No 8 2014, Pelimpahan Kewenangan Perizinan dan Non Perizinan Kepada Badan Perizinan Terpadu dan Penanaman Modal Kota Makassar (1 achievement BEE)
5. SK Kepala Dinas Kesehatan Kota Makassar No. 800/01.1/DKK/I/2013, Penunjukkan/Pengangkatan Anggota PPID Dinas Kesehatan Kota Makassar (1 achievement PPID)
6. Perbup Luwu No 40 2013, Persalinan Aman dan Pemberian Air Susu Ibu (ASI) (2 achievements Health)
7. Perbup Luwu Utara No 24 2013, Pelaksanaan Persalinan Aman, Inisiasi Menyusu Dini Dan Pemberian Air Susu Ibu Eksklusif (3 achievements Health)
8. Perbup Luwu Utara No 13 2013, Pedoman Pengelolaan Dan Pelayanan Informasi Dan Dukumentasi Pemerintah Kabupaten Luwu Utara (1 achievement PPID)
9. Keputusan Bupati Barru Nomor 821 – 240 Tentang Mutasi Guru Di Lingkungan Pemerintah Kebupaten Barru (1 achievement Education)
10. Keputusan Bupati Luwu Nomor 332/VII/2014 tentang Pembentukan Tim Teknis Pelayanan Perizinan, Non Perizinanan dan Penanaman Modal Kabupaten Luwu (1 achievement BEE)

11. Peraturan Bupati Luwu Nomor 27 Tahun 2014 tentang Pelimpahan Kewenangan Pelayanan Perizinan, Non Periiznan dan Penanaman Modal Kepada Badan Pelayanan Perizinan dan Penanaman Modal (BPPPM) Kabupaten Luwu (2 achievements BEE)
12. Peraturan Gubernur Sulawasi Selatan Nomor 13 Tahun 2013 tentang Pejabat Pengelola Informasi dan Dokumentasi Pemerintah Daerah Provinsi Sulawasi Selatan (1 achievement PPID)
13. *Keputusan Kepala Kantor Pelayanan Terpadu Satu Pintu Kabupaten Bantaeng Nomor 503/10/VII/2014 (1 achievement BEE)*
14. *Keputusan Kepala Badan Pelayanan Perizinan Terpadu Kabupaten Bone Nomor 14 Tahun 2014 tentang Pembentukan Tim Penanganan Pengaduan Pada Bada Pelayanan Perizinan Terpadu Kabupaten Bone (1 achievement BEE)*
15. *Keputusan Bupati Enrekang Nomor 453/KEP/VIII/2014 Tentang Pembentukan Tim Teknis Pada Kantor Penanaman Modal dan Pelayanan Terpadu Satu Pintu Kabupaten Enrekang Tahun 2014 (1 achievement BEE)*
16. *Peraturan Daerah Kebupaten Pangkajene Dan Kepulauan Nomor 3 Tahun 2014 tentang Perubahan Kedua Atas Peraturan Daerah Kabupaten Pengkajene dan Kepulauan Nomor 12 Tahun 2007 tentang Organisasi dan Tata Kerja Lembaga Teknis Daerah Pemerintah Kabupaten Pengkajene dan Kepulauan (1 achievement BEE)*
17. *Peraturan Bupati Pinrang Nomor 2 Tahun 2013 tentang Pendelegasian Kewenangan Penerbitan Izin Usaha dan Izin non Usaha Kepada Kepala Bandan Pelayanan Perizinan Terpadu dan Penanaman Modal Kabupaten Pinran (1 achievement BEE)*
18. *Keputusan Bupati Pinrang Nomor 503/27/2014 Tentang Pendelegasian Wewenang Pemberian Perizinan dan Non Perizinan di Bidang Penanaman Modal Kepada Kepala Badan Pelayanan Perizinan Terpadu dan Penanaman Modal Kabupaten Pinrang (1 achievement BEE)*
19. *Peraturan Bupati Sinjai Nomor 36 Tahun 2013 Tentang Pelimpahan Kewenangan Pengelolaan dan Penandatanganan Perijinan dan Non Perijinan Pada Badan Penanaman Modal dan Pelayanan Perijinan Kabupaten Sinjai (2 achievements BEE)*
20. *Peraturan Bupati Sinjai Nomor 41 Tahun 2013 tentang Mekanisme/Prosedur, Persyaratan, Biaya dan Waktu Proses Perijinan Pada Pelayanan Perijinan Terpadu Satu Pintu Di Kabupaten Sinjai (1 achievement BEE)*
21. *Peraturan Bupati Sinjai Nomor 41 Tahun 2013 tentang Mekanisme/Prosedur, Persyaratan, Biaya dan Waktu Proses Perijinan Pada Pelayanan Perijinan Terpadu Satu Pintu Di Kabupaten Sinjai (1 achievement BEE)*
22. *Keputusan Bupati Soppeng Nomor 61/II/2014 tentang Pembentukan Tim Penyederhanaan Pelayanan Perizinan Pada Kantor Pelayanan Terpadu Kabupaten Soppeng (1 achievement BEE)*
23. *Peraturan Bupati Soppeng Nomor 8/Per-Bup/IV/2014 tentag Pelimpahan Kewenangan Pelayanan Perizinan dan Non Perizinan Kepada Kantor Pelayanan Terpadu Kebupaten Soppeng (1 achievement BEE)*
24. *Peraturan Bupati Soppeng Nomor 7/Per-Bup/IV/2014 Tentang Penyederhanaan Perizinan dan Non Perizinan di Kabupaten Soppeng (1 achievement)*

25. *Peraturan Bupati Soppeng Nomor 15/Per-bup/VII/2014 tentang Mekanisme dan Tata Cara Pelayanan Perizinan dan Non Perizinan serta Penanganan Pengaduan Pada Kantor Pelayanan Terpadu Kabupaten Soppeng (1 achievement BEE)*
26. *Peraturan Bupati Soppeng Nomor 22/Per-Bup/IX/2014 tentang Standar Pelayanan dan Standar Operasional Prosedur Pelayanan Perizinan dan Non Perizinan Pada Kantor Pelayanan Terpadu Kabupaten Soppeng (1 achievement BEE)*
27. *Keputusan Kepala Kantor Pelayanan Terpadu Satu Pintu dan Penanaman Modal Kabupaten Takalar Nomor 06 Tahun 2014 tentang Pembentukan Tim Pengaduan, Mekanisme dan Standar Pelayanan Penanganan Pengaduan Pada Kantor Pelayanan Terpadu Satu Pintu dan Penanaman Modal Kabupaten Takalar TA 2014 (1 achievement BEE)*

Annex A-4: Kinerja Grants – FY 2014

No	Grantee/Contractor	Type	Project Location	Start	Finish	Extension Start Period	Extension End Period	Purpose
1	Center for Studies and Development Indonesian Human Intellectual (CORDIAL)	EDU - SBM	South Sulawesi Province: Barru District	1-Sep-12	31-Oct-13	1-Nov-13	31-Oct-14	To improve local governments technical skill and policy in school based management in Barru District, South Sulawesi
2	Lembaga Pelatihan dan Konsultasi Inovasi Pendidikan (LPKIPI)	EDU-SBM & PTD	1 district in East Java Province: Bondowoso and 2 districts in West Kalimantan: Sambas and Singkawang	1-Sep-12	31-Oct-13	1-Nov-13	31-Dec-14	On Proportional Teacher Distribution (PTD) with the West Kalimantan Provincial Education Office (PEO), District Government and District Education Office (DEO) and Multi Stake Holder Forum (MSF) of Sambas and the district of Bondowoso in East Java: On School Based Management (SBM) to work with the District Education Office and 20 partner schools in Singkawang City, to develop a participative, transparent and accountable process at school governance leading to improved quality of education
3	Pusat Kajian Pendidikan dan Masyarakat (PKPM)	EDU - SBM	Aceh Province: Bener Meriah District	1-Oct-12	31-Oct-13	1-Nov-13	31-Oct-14	School-based Management - Technical Assistance and Mentoring
4	Yayasan Demokrasi Untuk Negeri (DAUN)	EDU - MSF PTD	Aceh Province: Aceh Singkil District	1-Dec-12	30-Nov-13	1-Dec-13	31-Dec-14	Strengthening local multi stake holder forum in policy advocacy on Proportional Teachers Distribution
5	Gerakan Anti Korupsi (GeRAK)	EDU - BOSP	2 districts in Aceh : Banda Aceh and Simeulue	15-Oct-12	31-Jul-13	15-Nov-13	14-Nov-14	School Unit Operational Cost - Technical Assistance and Mentoring
	Subtotal Education							
6	YayasanPemberdayaan Intensif Kesehatan Masyarakat (YAPIKMA)	HEALTH	East Java Province, Probolinggo Municipality and Jember District	1-Sep-12	30-Nov-13	1-Dec-13	31-Oct-14	Kinerja Health Package Implementation - East Java

No	Grantee/Contractor	Type	Project Location	Start	Finish	Extension Start Period	Extension End Period	Purpose
7	Forum Informasi & Komunikasi Organisasi Non Pemerintah (FIKORNOP) Sulawesi Selatan	HEALTH	South Sulawesi Province, Luwu and North Luwu District	1-Sep-12	30-Nov-13	1-Dec-13	31-Oct-14	Kinerja Health Package Implementation - South Sulawesi
8	Lembaga Perlindungan Anak (LPA) Tulungagung	HEALTH	East Java Province: Probolinggo and Tulungagung District	1-Sep-12	30-Nov-13	1-Dec-13	31-Oct-14	Kinerja Health Package Implementation- East Java
9	Pusat Kajian dan Perlindungan Anak (PKPA)	HEALTH	Aceh Province, Simeulue and Aceh Tenggara District	1-Sep-12	30-Nov-13	1-Dec-13	31-Oct-14	Kinerja Health Package Implementation- Aceh
10	Komite Pemantau Legislatif (KOPEL)	HEALTH	South Sulawesi Province, Makassar and Bulukumba District.	1-Sep-12	30-Nov-13	1-Dec-13	31-Oct-14	Kinerja Health Package Implementation - South Sulawesi
11	PKBI Kalbar	HEALTH	West Kalimantan Province: Bengkayang, Sambas and Melawi Districs West kalimantan	1-Feb-13	13-Mar-14	14-Mar-14	31-Dec-14	Kinerja Health Package Implementation - West Kalimantan
	Subtotal Health							
12	Jurnal Celebes	MEDIA	All District, South Sulawesi	1-Feb-13	31-Jan-14	16-Apr-14	15-Nov-14	Increasing the Role of Mainstream and Citizen Journalist in Advocacy to Improve Public Service Delivery – South Sulawesi Province
13	Kajian Informasi, Pendidikan dan Penerbitan Sumatera (KIPPAS)	MEDIA	All District, Aceh	1-Feb-13	31-Jan-14	16-Apr-14	15-Nov-14	Increasing the Role of Mainstream and Citizen Journalist in Advocacy to Improve Public Service Delivery – Aceh Province

No	Grantee/Contractor	Type	Project Location	Start	Finish	Extension Start Period	Extension End Period	Purpose
14	Pusat Kajian Komunikasi (PUSKAKOM)	MEDIA	All District, East Java	1-Mar-13	31-Mar-14	1-Apr-14	20-Dec-14	Strengthening the role of media to encourage better quality of public services in 5 (five) Districts/ City, East Java
15	Lembaga Pengkajian dan Studi Arus Informasi Regional (LPS AIR)	MEDIA	All District, West Kalimantan	15-Mar-13	14-Mar-14	15-Mar-14	14-Nov-14	Strengthening the role of media to encourage better quality of public services in 5 (five) Districts/ City, West Kalimantan
16	The Jawa Pos Institute of Pro Otonomi (JPIP)	MEDIA	All Districts in West Kalimantan, South Sulawesi and East Java	15-May-13	1-May-14	2-May-14	31-Dec-14	Improving documentation quality, information distribution and public services innovation replication through Autonomy Award in East Java, South Sulawesi and West Kalimantan Province.
	Subtotal Media							
17	Perkumpulan Serikat Pengembang Swadaya Masyarakat (SEPAKAT)	MSF	All District, Aceh	1-Jan-14	31-Dec-14			Strengthening linkages between district and service delivery unit level Multi Stakeholder Forums to improve public service delivery in Kinerja's five Partner District in Aceh Province
18	Lembaga Pengkajian Kemasyarakatan dan Pembangunan (LPKP)	MSF	All District, East Java	16-Dec-13	15-Dec-14			Strengthening linkages between district and service delivery unit level Multi Stakeholder Forums to improve public service delivery in Kinerja's five Partner District in East Java Province
19	Pusat Pengembangan Sumberdaya Wanita (PPSW)	MSF	All District, West Kalimantan	16-Dec-13	15-Dec-14			Strengthening linkages between district and service delivery unit level Multi Stakeholder Forums to improve public service delivery in Kinerja's five Partner District in West Kalimantan Province
20	Yayasan Esensi	MSF	All District, South Sulawesi	1-Jan-14	31-Dec-14			Strengthening linkages between district and service delivery unit level Multi Stakeholder Forums to improve public service delivery in Kinerja's five Partner District in South Sulawesi Province
	Subtotal MSF							

No	Grantee/Contractor	Type	Project Location	Start	Finish	Extension Start Period	Extension End Period	Purpose
1	Perkumpulan untuk Pengembangan Usaha Kecil (PUPUK), Surabaya	BEE	East Java, District Probolinggo and Tulungagung	22-Feb-13	22-Jan-14		31-Dec-14	Technical Assistance to improve the business-enabling environment (BEE) in the province of East Java, specifically Kab Probolinggo and Tulungagung district
2	Yayasan Adil Sejahtera (YAS), Makassar	BEE	South Sulawesi, District Makassar and Barru	22-Feb-13	22-Jan-14		31-Dec-14	Technical Assistance Program To Increase Business environment for Provincial Government of South Sulawesi, Barru district and District Makassar
3	Yayasan BITRA Indonesia, Medan	BEE	Aceh, district: Simeulue, Singkil	22-Feb-13	22-Jan-14		31-Dec-14	Technical Assistance Program To Increase Business environment for Provincial Government of Aceh, Singkil district and District Simeulue
4	Madanika, Pontianak	BEE	West Kalimantan: Melawi district	22-Feb-13	22-Jan-14		31-Dec-14	Technical Assistance Program To Increase Business environment for Provincial Government of West Kalimantan, Melawi district
5	The National Secretariat of the Indonesian Forum for Budget Transparency (Seknas FITRA)	BEE	20 Kinerja Districts	17-Jun-14	31-Dec-14			Local Budget Study (Round 2) in 20 KINERJA Districts/Municipalities
	Subtotal BEE							
	Grand Total							

Part B: Kinerja Papua Quarterly Report

This section of the overall Kinerja Program and Papua Expansion Quarterly Report includes the quarterly report for the Papua Expansion and includes the province of Papua and the four designated districts within the province. It covers the reporting period from October 2013 – September 2014, the same period of time as the Kinerja Program Quarterly Report, which is presented in Part A: Kinerja Program Quarterly Report, of this document. Part A includes details on activities and achievements for the four original provinces and 20 original districts of the Kinerja Program.

1. Introduction

On March 15, 2012, the United States Agency for International Development (USAID expanded Kinerja's mandate to focus on governance in health systems strengthening (HSS) in the four target districts[25] of Jayapura, Kota Jayapura, Jayawijaya and Mimika (see Annex B-1: Kinerja Papua Map).

The Kinerja approach in Papua (Kinerja Papua) builds on the body of existing innovative practices in governance and public service delivery (PSD) and adjusts them to district needs, and then adapts its current approaches to strengthen health systems and enhance health outcomes.

The Kinerja objectives in Papua are to develop and ensure the capacity of local governments to deliver effective, safe, and quality personal and non-personal health services, with a minimum waste of resources, while promoting the following:

- An enabling policy environment within the provincial health systems
- Governance that results in a relevant and responsive health system
- The substantive engagement of civil society

Program activities are directed at HSS to improve the government's ability to provide quality services to those communities most at risk for infectious disease, including human immune deficiency virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) and tuberculosis (TB), and for strengthening maternal and child health (MCH).

The Kinerja approach in Papua (Kinerja Papua) builds on the body of existing innovative practices in governance and public service delivery that are adapted to district needs, and adapt its current approaches to strengthen health systems and enhance health outcomes. Kinerja Papua seeks to complement an existing range of USAID partner programs in the four target districts by identifying and targeting the key blockages to health service delivery in Papua.

This report covers the broader activities of Kinerja Papua, but also illustrates how the team has operated in the districts over the previous year. It outlines the following:

- An overview of project objectives and results in Papua
- Challenges and risks
- A description of the FY 2013 work program
- An overview of project management and monitoring and evaluation
- Information on grants management

1.1 Program Background and Context

USAID is making considerable investments in health, with a specific focus on Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS), Maternal and Child Health (MCH), and Tuberculosis (TB), through a range of projects and partners. Although these projects are making significant inroads at the technical level, the health sector continues to be poorly governed and is characterized by poor definitions of roles and

[25] See the Definitions section in the front matter for explanation of use of the terms "districts" and "target districts" for the purposes of this document.

responsibilities, low attendance rates by health workers in health facilities, insufficiently stocked health centers and other facilities, and a lack of outreach services.

As such, USAID considers that targeted multi-sectoral efforts at the governance level will strengthen outcomes and hasten improvement in the health standards of the people of Papua. To this end, USAID expanded the scope of the current Kinerja project to focus on HSS in the four target Papua districts Jayapura, Jayawijaya, Kota Jayapura and Mimika.

1.2 Objectives and Results

Kinerja's objectives in Papua are to develop and ensure the capacity of local governments to deliver effective, safe, and quality personal and non-personal health services, with a minimum waste of resources, while promoting the following:

- An enabling policy environment within the provincial health systems;
- Governance that results in a relevant, responsive, health system;
- And the substantive engagement of civil society.

Project activities are expected to be directed at HSS to improve the government's ability to provide quality services to those communities most at risk for infectious disease, including HIV/AIDS and TB and for strengthening MCH.

2. Building Relationships with Local Government

2.1 Project Management Committee (PMC)

During FY 2014, Kinerja Papua found itself working in a transitional time for the provincial government and two of its district governments, Mimika and Jayawijaya. In the first quarter of the year, the provincial government began the process of replacing leadership at technical office level including the Provincial Health Office. This leadership change was then followed by policy changes to bring the government in line with the vision of the newly elected governor. The early portion of the year also featured a district head election in Jayawijaya, which ran smoothly compared to Mimika, where the process was marred by high political tensions and social conflict. The transitional nature of this year had both direct and indirect consequences on the program's relations with local governments.

Leadership changes at the provincial level also changed the composition of the PMC/Health Working Team. The Provincial Health Office changed its leadership twice during FY 2014, with Aloysius Giay as the current head of office and also the head of the Unit for Accelerated Development of Papuan Health (*Unit Percepatan Pembangunan Kesehatan Papua* –UP2KP). Following the installation of a new head of the Provincial Health Office, structural change and staff rotations affected nearly the entire staff. This situation required Kinerja Papua and BaKTI to spend additional time to reorganize the PMC and reintroduce itself to the new members of PMC/Health Working Team before it could regain the forum's trust and support.

In Q2, the Provincial Health Office appointed Kinerja Papua to organize and facilitate the Health Partner Forum at the provincial level, which served as a platform for the new head of the Provincial Health Office to introduce himself and his new programs to health development partners in Papua. The Provincial Health Office also actively involved and worked with PKMK-UGM to develop a logbook for contract doctors as a part of the Kinerja Papua intervention. Along with this support, the Provincial Health Office committed to implement

the logbook in a pilot project together with Kinerja Papua's four project districts. In addition to all of these achievements, the Provincial Health Office requested Kinerja Papua to support finalization of Strategic Planning Document (Renstra Dinas) in the final months of the fiscal year – which underlines the extent to which the program has rebuilt positive working relationships despite high levels of turnover among key government partners.

2.2 District-level Technical Teams

At the district level, the electoral process in Jayawijaya and Mimika did not bring about changes in the technical team structure until the third quarter of the year. Kinerja Papua received reliable support from the local government via the District Health Office (DHO), Bappeda, and other Technical Team members. The DHO in Jayawijaya has so far demonstrated strong levels of commitment and has provided institutional support for Kinerja project implementation through a DHO decree to implement standard operating procedures (SOPs) on *puskesmas* service delivery throughout the district. In the final quarter of the year, the DHO in Jayawijaya further extended its support by providing a legal framework for the piloting of the contract doctor logbook. In Mimika, technical team members requested Kinerja Papua to facilitate the development of the District Health System framework together with Public Health and Malaria Control (PHMC) from PT Freeport Indonesia.

Both in Jayapura and Kota Jayapura, technical team members demonstrated high commitment to and support for Kinerja's work in integrating Minimum Service Standards (MSS) into health planning and budgeting documents for 2014. At the technical level, the Bappeda office in Jayapura extended funding support for a technical coordination meeting on the 2014 budget – a rare display of commitment in a province where donor programs are typically expected to cover such expenses to even get participants in the room. Beyond supply-side changes, the head of Jayapura's DHO demonstrated committed to institutionalizing the MSF as the Puskesmas Trustee Council (*Dewan Penyantun Puskesmas*) and in response to technical recommendation formulated out of public complaint surveys, the DHO has increased its incentive package to attract more health workers to the district.

Beyond district-level governments, Kinerja Papua's partner *puskesmas* have demonstrated exceptional levels of commitment and support. Their staff have utilized the online and offline Performance Management and Leadership (PML) training offered by PKMK UGM, to not only identify key areas for improvement in HIV/AIDS, TB and Safe Delivery, but to also design and implement follow-up plans. In Jayawijaya and Mimika, all of the *puskesmas* working with Kinerja Papua developed plans of action, a key part of the PML program, into their annual work plans. Meanwhile, in Jayapura and Kota Jayapura, 6 non-partner *puskesmas* joined Kinerja Papua to integrate MSS into their planning and budgeting documents.

Local Government Commitment and Support to Kinerja Papua

Government	Commitment / Support
Provincial	Support to develop Logbook for Contracted Doctor (Dokter PTT) Request to develop MSS based Renstra Dinkes Balatkes adopting PML Training
Jayapura City	Budget allocation for Technical Team meeting Integrating MSS on planning and budgeting documents 2014
Jayapura District	Integrating MSS on planning and budgeting documents 2014 Institutionalizing MSF as Dewan Penyantun Puskesmas Adopting Technical Recommendation
Mimika District	Support to develop District Health System (Sistem SKD) SK DInkes on MSS targeting for Puskesmas
Jayawijaya District	Head of DHO Decree (SK Kadinkes) on Puskesmas Service SOP implementation) Support to integrate MSS in Puskesmas Plan of Action SK Kadinkes on Piloting Logbook for Contracted Doctor

In the coming year, Kinerja Papua aims to strengthen its relationships with provincial and district governments to further replicate Kinerja Papua initiatives at the service delivery unit level, both on the supply and demand sides. Through PMC at the provincial level and technical teams at the district level, Kinerja will also seek the commitment of district governments to institutionalize and to ensure the sustainability of the program's initiatives.

3. Innovations and Incentives

3.1 Strengthening Leadership and Management Capacity for Health Service Delivery

As part of its commitment to strengthening leadership and management capacity for health service delivery, Kinerja continued its partnership with the Center for Health Service Management of the Gadjah Mada University Faculty of Medicine (*Pusat Manajemen Pelayanan Kesehatan* – PMPK UGM) to offer online, distance-learning education as well as face-to-face mentoring.

In Q1, PMPK UGM drew to the close of its first grant, and focused on the finalization of short-term follow-up plans, paying special attention to involve MSFs as a key part of the implementation. PKMK UGM conducted as series of online and offline mentoring activities to ensure in-depth understanding on the topics discussed in the past.

PKMK UGM also collaborated with Provincial level Health Training Agency (*Balai Pelatihan Kesehatan* – Balitkes) to conduct monitoring of action plan implementation. PKMK UGM also evaluated their first-year performance management and leadership (PML) interventions by hiring consultants from outside the organization.

Kinerja Papua – through PKMK UGM – provided further mentoring assistance as the short-term follow-up plans that were developed in the face-to-face training entered the implementation phase. From the monitoring of action plans conducted by PKMK UGM and the Health Training Agency of Jayapura, Kinerja Papua recorded that DHOs in four districts have implemented their 24 short-term action plans covering implementation related to HIV/AIDS, TB and Safe Delivery – this is a 200 percent achievement from Kinerja Papua Year 4 targets. In addition, 12 *puskesmas* also have implemented or partially implemented their 71 short-term action plans – a 197 percent achievement against Kinerja Papua Year 4 targets. As a result of follow-up discussions, the Health-Care Training Agency of Jayapura agreed to conduct further monitoring and evaluation of each *puskesmas*, and an external evaluation by the international NGO IDEA was planned for December 2013.

The short-terms action plans related to TB, HIV/AIDS and MCH achieved by *puskesmas* and DHOs, including:

- Jayapura Kota: Development of SMS gateaway system to support health information system on antenatal and delivery services; optimalization of Mayor decree no. 12/2013 on city technical offices in charged of *posyandu*; formulation of Mayor decree for the a Reproductive Health Centre.
- Jayapura District: Mentoring of laboratory technicians with error rates >5% for TB testing; health education campaigns on co-infection of TB/HIV at the community and village level.
- Mimika District: Establishing partnership between midwives and traditional birth attendants at *puskesmas* level; mapping of traditional birth attendance at local level; development of 24-hour midwives on call shift at *puskesmas.*
- Jayawijaya District: Development of DHO strategic planning encompassing multi-year planning for HIV, TB and MCH; health education campaigns on coinfection of HIV/TB at community and village level in collaboration with religious leaders.

The program found that while a majority (81 percent) of participants in PKMK UGM's training portion showed improvements in their knowledge of management and leadership topics (PMEP indicator 7 – Annex B-1), the online portion of the PML program suffered from a number of problems. Unstable internet connections in the province had significantly eroded the little time reserved for online mentoring, which left many participants unable to ask resource persons additional questions. Many participants were also generally unfamiliar with how to use the internet, which created difficulties in their accessing the PKMK UGM website. This information was taken into account during the process of negotiating with PKMK UGM for their second year proposal.

In Q2, Kinerja Papua engaged in a prolonged negotiation process with PKMK UGM regarding its proposal for a second round of funding. These discussions took into account the valuable feedback provided by USAID, as well as the program's own observation of the PML program's effectiveness. However, the issuance of a follow-on grant to PKMK UGM was disrupted by a no-cost extension (NCE) was processed to extend their grant from its December end-date until January 31, and prolonged close-out procedures that followed. A new grant was processed and approved in February. With the new grant in place, the program saw activities begin to resume a normal schedule toward the end of the quarter.

During Q2, the Kinerja Papua program team also conducted additional trainings for government staff. Kinerja staff, in partnership with LAN, conducted a complaint survey workshop in January that was attended by 43 participants including staff from DHO, Balatkes, and Kinerja's partner *puskesmas* from all four Kinerja Papua districts.

Under this second grant PKMK UGM provided advanced PML training, which resumed in Q3 in all four districts, focusing on the integration of MSS into service delivery unit work plans and data management and analysis.

By the end of FY 2014, PKMK UGM completed two out of the four trainings planned for that fiscal year in four Kinerja Papua districts. The two trainings conducted in FY 2014 were "Improvements of Data Collection and Processing Systems" and "Health Service Delivery Units' Planning."

Of the 197 participants trained in FY 2014, 116 (84 female, 72 percent) were specifically trained by PKMK UMG. In addition to the participants who completed the two PKMP UMG training sessions, 81 participants (55 female, 68 percent) completed the SOP and MSS Costing training conducted by Kinerja Papua LPSS staff in Jayapura. Overall, 120 participants of the 197 were trained in Q4.

The remaining two trainings will focus on the specific needs of each district and are scheduled for Q1 2015**.** The delay of these trainings is due to a late start of PKMK UMG's second year grant, which only started on Feb. 1. Local political issues also caused challenges in finalizing schedules of trainings, especially considering the high turnover within service unit staff after the legislative elections in April.

Support was provided through face-to-face and on-the-job training, having learned from the challenges of using Skype-based long-distance support in the last year.

As a result of PKMK UGM's assistance, a total of 113 medium-term action plans were produced and finalized by Kinerja Papua's partner *puskesmas* and DHO in all four districts during this reporting period. No additional achievements were recorded in Q4 as health service delivery units focused on the implementation of the medium-term action plans formed in the previous quarter. Examples of medium-term action plans finalized by the *puskesmas* and DHOs including:

- Jayapura Kota: Increasing capacity of *puskesmas* health laboratory technicians on STI, HIV and TB testing; training to establish Siaga village; seminar with *posyandu* cadres, training of HIV program managers at *puskesmas* and DHO; on-the-job training for laboratory technicians at *puskesmas* and hospital on TB services.
- Jayapura District: Health education campaigns about TB to the community and family of TB patients, recruitment of laboratory technicians in *puskesmas.*
- Jayawijaya District: Establishing multi-sector mobile clinic with religious leaders, indigenous leaders, *puskesmas* staff, home visit for TB and HIV patients.
- Mimika District: Development of district health system; partnerships between midwives and traditional birth attendance; health promotion and education activities on safe delivery thorouhg health facilities'campaigns.

In Mimika, Kinerja continued to support the development of Mimika Health System to follow up DHO's long-term action plan. The development of this district health system also involves the private sector – PT Freeport Indonesia Public Health Malaria Control (PTFI-PHMC) and an NGO established from the Freeport Fund, *Lembaga Pengembangan Masyarakat Amungme and Komoro* (LPMAK). A small working taskforce involving all stakeholders was developed to design and to draft the district health system document. Some of the activities to produce the district health system will be funded by local government, PT Freeport Indonesia and Kinerja, especially for the public consultation. In Q3, one workshop was held and produced a road map for the health system's establishment. Following this a consultant has been recruited by PTFI PHMC to facilitate the process of finalizing a draft of Mimika Health System with local stakeholders. Once the draft is developed in FY 2015, Kinerja will support public consultation at the community level and advocacy with DPRD to ensure that it is turned into regulation.

In August 2014, PKMK UGM held a meeting in Yogyakarta that was attend by representatives from the Papua provincial health office and BAPPEDA to discuss the sustainability of the PML

program in Papua, including advocacy related to programming budgets and how to help Balatkes to meet training needs in Papua's health sector

3.1.1 Standard Operating Procedures

Kinerja Papua provided support for the adoption of standard operating procedures (SOPs) on pathways of service and other non-technical SOPs to help ensure the delivery of high-quality health care services in HIV/AIDs, TB and MCH.

Drafts of these SOPs were produced in the early part of FY 2014 and further refined, which provided an opportunity to improve coordination between *puskesmas* and DHO officials in Jayawijaya.

In Q2, SOPs were signed by the DHO in three non-partner *puskesmas* in Jayawijaya – Puskesmas Ilekma, Puskesmas Assolokobal and Puskesmas Wamena Kota. These SOPs were created after government staff attended a Kinerja SOP workshop in January 2013. Further monitoring found that Puskesmas Ilekma and Puskesmas Assolokobal implemented four out of the eight SOPs signed by the DHO, while Puskesmas Wamena Kota implemented two out of the eight SOPs. These efforts were further supported when a new local regulation was signed in Q3 in Jayawijaya to institutionalize eight SOPs in all *puskesmas* from a legal standpoint. The districts of Jayapura and Kota Jayapura also replicated SOPs to two additional *puskesmas*, each.

Kinerja continued pushed for the broader adoption of SOPs at additional *puskesmas,* and a workshop to this end were held in Q4 in Jayapura. Representatives from all 19 *puskesmas* in Jayapura attended this training and produced draft SOPs to improve service quality.

Anecdotal evidence from the field suggests that SOPs have led to noticeable improvements in service delivery. Patients have commented that standardized service flows provide them with more certainty in terms of where and when they will be served. As implementation got underway, some patients found it confusing to have to check in at reception first, though this has helped *puskesmas* to be more orderly and efficient. MSFs have said that SOPs have raised awareness among health workers on confidentiality about HIV/AIDS, and also promoted equality in service delivery. Whereas previously, friends and relatives of *puskesmas* staff were served first, patients are now handled on a first-come-first-served basis.

In the coming fiscal year, meetings will be held to refine SOPs and their application, after which it is expected that SOP teams in *puskesmas* will monitor and evaluate SOP implementation.

3.1.2 Absenteeism

Anecdotal data suggests that absenteeism is a problem that contributes to poor quality of health services and poor sustainability of programs and donor investments in HIV, TB and MCH services in Papua. Kinerja Papua conducted a study aimed at exploring the magnitude and dimensions (social, cultural, structural, geographical and demographic) of health providers' absenteeism in the program's four partner districts. It also aimed to explore the policy roots of the problem, as distinguished from operational- , local- , and national-level causes. Health providers assessed consisted of doctors, nurses and midwives who provide services at the *puskesmas* level in Kinerja Papua districts. As a two-pronged study, the study incorporated both quantitative data from structured interviews with health-care workers – conducted from 9:30–10:30 a.m. – and qualitative data obtained from in-depth policymaker interviews and

public focus group discussions. This approach was adopted to provide a holistic overview of the factors that contribute to absenteeism and potential solutions, which can also affect the successes of health focused programs as in HIV/AIDS, TB and MCH.

In early December 2013, Kinerja Papua conducted the explorative stage of the study to inform further plans and to develop a first draft of the survey questionnaires. One STTA was hired to visit all four districts to obtain initial data/information on existing health workers posted in *puskesmas* in each districts – numbers, disaggregated data on gender, professions.

While trying to obtain information from local stakeholders, the STTA also started to explore the perspective of policy-makers and DHO officials on health workers' absenteeism. On Feb. 10, the consultant shared their preliminary findings, which indicated a lack of up-to-date data among partner DHOs on *puskesmas* staff postings – one district's data nearly a year out of date. With this challenge identified beforehand, steps were taken during the conduct of the study to incorporate secondary *puskesmas*-level data to improve the accuracy of the findings.

Following a competitive bidding process in Q2, SURVEYMETER was selected to conduct the survey, and after a period of negotiation, a contract was signed on April 1.

Kinerja Papua then facilitated a pilot testing of the absenteeism study in Jayapura on April 14-18. The initial test resulted in a number of improvements, including gender-sensitive selection of respondents and the inclusion of community leaders as respondents for in-depth interviews.

A number of difficulties were encountered during data collection. Many target respondents were difficult to locate, since their home addresses were not on file with the *puskesmas* or the local health department. Difficult terrain and a lack of basic infrastructure made transportation difficult, contributing to challenges in data collection, especially in remote *puskesmas.*

However, these problems were overcome, and data collection concluded in early July. A total of 346 medical workers had been surveyed, some 29 in-depth interviews conducted, and 30 FGDs conducted at 53 *puskesmas.*

After the data was cleaned and analyzed, it revealed varying rates of absenteeism among Kinerja Papua districts. The following table summarizes the results.

District	% Absent
Jayapura	52 percent
Mimika	40 percent
Jayawijaya	33 percent
Kota Jayapura	21 percent
Average	35.4 percent

During the interviews, health-care workers provided the following reasons for their absence:

- Illness, either personal or of a family member;
- Approved personal leave;
- Attending pre-approved trainings, events or lectures;
- Competing professional commitments, such as private medical practice;
- Family commitments;
- Security issues;
- Natural disasters;
- Inclement weather;

- Difficulties in transportation;
- Poor working conditions;
- And some declined to explain their absence.

A number of recommendations emerged from the study, including:

- Serious attention needs to be paid to the characteristics of health care providers to determine what kind of policy that should be taken
- Improvements in DHO monitoring are needed, not in terms of increasing the frequency of supervisory visits, but rather the substance of the surveillance
- Improvements in *puskesmas* conditions are greatly needed – particularly in terms of service support functions, such as the variety and quantity of available drugs and medical equipment, and in non-service support facilities, such as the availability of adequate building facilities, water resources, electricity, means of communication, waste management and security.

From these recommendations, Kinerja Papua will work in the coming year to facilitate workshops at the provincial and national level to disseminate the findings of the absenteeism study; conduct a series of FGDs to follow up on the study's recommendations; and facilitate advocacy activities (development of policy briefs, public consultations, hearings, etc.) with key stakeholders to ensure policies, programs, and budgetary resources are made available to improve attendance of health workers.

3.1.3 Logbook on Contract Doctors

At the provincial level, the Papua Health Office asked Kinerja Papua to facilitate the development of a scope of work (SOW) and a performance logbook for contract doctors (PTT). The performance log book was envisioned be used as a tool to provide work direction and performance monitoring for medical professionals who had been retained under contract by the provincial government to provide services specifically for remote and isolated areas which face HIV/AIDS problems and are heavily underserviced. The DHO of Jayawijaya also faced the same need for the management of its PTT staff.

Drafts of the SOW and logbook were prepared based on a series of workshops and focus group discussions involving key stakeholders and were submitted to provincial partners in Q2. However, due to ongoing staff transfers within the provincial government, Kinerja Papua did not receive any additional feedback by the close of the quarter and felt it imprudent to press the issue until new government counterparts had settled into their new positions.

PKMK UGM conducted an assessment of the draft logbook in all four partner districts during Q3 in order to test its applicability and examine if any further revisions need to be made before broad-scale implementation. Preliminary results from this assessment were then presented to DHO officials from Kinerja's partner districts in July.

A three-month pilot implementation of the logbook began in September in Jayawijaya dan Mimika district, and not only covers national contracted doctors but also civil servant doctors and contracted doctors by the district of Jayawijaya. A total of 34 doctors, consisting of 30 general practitioners and four dentists, will be covered by this pilot program. Initial uptake was slower in Mimika, where four doctors joined the pilot program. As of this writing, pilot programs had also been launched in Jayapura (four doctors) and Kota Jayapura (six doctors). In one of the pilot project areas, a system of social accountability has been introduced, where

the logbook acknowledgement is done by local religious or community leaders (TBD) living near the puskesmas, rather than the *puskesmas* head.

Some initial challenges have been encountered, including the fact that the logbook did not accommodate dentists, and doctors had difficulties in properly filling out paperwork due their busy schedules and due to a lack of operational definitions for the medical services they perform at the *puskesmas*.

Kinerja Papua advised PKMK UGM to incorporate community elders in the supervision of pilot logbook programs. PKMK UGM will conduct further monitoring and evaluation of the pilot in November 2014.

3.2 MRP/DPRD

As stated in the introductory chapters of this report, Kinerja Papua found itself working in a transitional time for the provincial government and two of its district governments, Mimika and Jayawijaya. Nowhere was this more apparent than in the program's work with local legislative councils (DPRDs) and with the Papuan People's Council (MRP).

Working through KOPEL and Yayasan Konsultasi Independen Pemberdayaan Rakyat (KiPRa), the program sought to improve the oversight and budgeting processes of DPRDs while simultaneously strengthening the capacity of the Papuan People's Assembly (Majelis Rakyat Papua – MPR), indigenous groups and faith-based institutions. The program's support focused on empowering the traditional pillars of Papuan society in its four partner districts to use their positions to raise awareness about MCH, TB and HIV/AIDS.

As an early initiative, Kinerja Papua worked with KOPEL to assess the health budgets in its partner districts over the last five years and to summarize key trends. The findings of the initial assessment showed a strong correlation between poor quality of health care and low budget allocations. Kinerja Papua held a workshop for DPRD members and secretariat staff on Dec. 6, 2013 in order to disseminate the study's findings. This activity helped to raise awareness about the need for sufficient health budgets and to build legislative support for the use of MSS-based tools in improving health care among the 31 participants (8 women) who attended.

Political tensions regarding the schedule for a run-off election to select a new district head of Mimika reached a peak Q2, with tribal conflicts causing several casualties in the district. Activities were further disrupted by the April 9 legislative election, which distracted the attention of many DPRD members. However, despite these challenges, KOPEL was able to resume a relatively normal schedule of activities to strengthen local legislative councils in budgeting and conducting oversight of public service delivery. As planned, trainings in the post-election environment focused on improving DPRD members' understanding of public expenditure reports presented by the executive branch so they could be more effective in exercising their oversight authority. Due to the fact that many current members were not reelected in April and will not be returning when new members are inaugurated in October, KOPEL also worked to support the development of a work plan with the DPRD Secretariat in each district to sustain its work in educating new members about their budgeting and oversight responsibilities.

In the final quarter of FY 2014, KOPEL assisted DPRDs to review government accountably report for FY 2013 fiscal year, to review mid-year budget revisions for FY 2014 (with the exception of Mimika), to train CSOs and MSF members on budget literacy, and to establish links between MSFs and DPRD members to facilitate public service improvement advocacy.

Having received a grant in Q2, Kinerja Papua IO KiPRa required some time to recruit staff and establish its office before activities could get underway. However, work began in earnest in Q3, and KiPRa hosted a series of focus group discussions (FGDs) with traditional and religious leaders in all four districts to help identify shortcomings in the delivery of public services. With the results of these FGDs in hand, KiPRa engaged in a broad variety of activities over Q4, including work to raise awareness and assess the capacity of MRP members on MSS; to increase the capacity of indigenous groups and faith-based institutions on participatory needs analysis as they pertain to health issues; to raise awareness of indigenous groups and faith-based institutions on local planning and budgeting policy; to foster engagement between the MRP, indigenous groups and faith-based institutions; and to foster engagement between DPRDs, indigenous groups and faith-based institutions.

3.3 Enhancing Citizens' Understanding of their Health Rights

Media Production and Content Sharing

Throughout the reporting period, the Indonesian Association for Media Development (Perhimpunan Pengembangan Media Nusantara – PPMN) and Forum Lenteng (a local media NGO engaged by Kinerja in early FY 2014) enhanced citizens' understanding of their health rights through a broad range of activities. Throughout FY 2104, PPMN worked with 34 media outlets to provide regular programming or dissemination activities related to health issues. The 34 achievements include MOUs with 21 local media organizations (including radio stations, print media and TV stations), 12 *puskesmas*-level MSFs involved in community film screenings and one online website created by Forum Lenteng as the main outlet for dissemination of writing produced by citizen journalists.

FY 2014 was a productive year for both grantees. In the fourth quarter alone, PPMN and Forum Lenteng produced 73 media products, including 64 articles and photo essays written by PPMN and Forum Lenteng's citizen journalists, which focused on key aspects of maternal and child health, TB and HIV/AIDS from an personal perspective. The remaining nine were three Public Service Announcement, four talk shows and two feature articles published in the *Cendrawasih Post*, a daily newspaper published in Kota Jayapura. These high levels of productivity among both IOs led to a total of 551 media products produced in FY 2014.

Forum Lenteng has not only trained citizen journalists, but has helped to showcase their work on an online forum, Halaman Papua (www.halamanpapua.org). The website's audience has grown from 50 unique visitors during its launch month of December 2013 to an impressive 14,885 by the end of September. To overcome the obvious issues with online connectivity in the province, Forum Lenteng has held its own film screenings, distributed hard copy compilations of citizen journalist articles and distributed DVDs of their videos.

In FY 2014, a total of 128 radio talk shows and 26 public service announcements (PSAs) have been produced and aired with training and mentoring support from PPMN, with four talk shows aired on Rock FM and Radio Publik Mimika based in Kota Jayapura and Mimika, respectively, and three PSA recordings produced by PPMN and aired on local radio stations in Q4.

During the reporting period, media campaigns focused on topics such as: health budgets, sectorial health issues, and community rights to quality health services, including Minimum Service Standards (MSS), SOPs and complaint surveys.

Topics addressed through media campaigns

Media Channel	MCH, TB and HIV
Talk Shows	Living with HIV, co-infection of TB and HIV, rapid HIV test – advantages, disadvantages and how it is conducted, screening and outreach to TB patients I&EBF, the importance of four antenatal check-ups at *puskesmas*, gender-based violence
Public Service Announcement	Pregnant woman and antenatal care, adherence to ARV treatment, the importance of four antenatal check-ups at *puskesmas*
Television Features and News	Early diagnosis and treatment of TB, integrating HIV services into MCH
Printed Media	Caring for pregnant women living with HIV and campaigning for ARV treatment for newly born babies, maternal death as an issue of concern amongst pregnant women

The work of PPMN and Forum Lenteng has helped raise issues with absenteeism among doctors and other health workers, the risks and unsafe practices used by traditional birth attendants, and the impact of living with HIV/AIDS in a way that is accessible to everyday people, and that highlights the government's obligations to provide care to a certain standard.

Citizen Journalism

In early FY 2014, Kinerja engaged local media NGO Forum Lenteng to train citizen journalists in using alternative media, such as videos, to raise their concerns on health services. The organization established a media center in each Kinerja supported districts, where the citizen journalists gather to learn about video production. In addition, PPMN held a variety of training sessions and capacity development workshops have been held to boost the skills of citizen journalists.

In FY 2014, a total of 70 citizen journalists from PPMN and Forum Lenteng actively reported on local government performance and/or provided health information in the four Kinerja Papua districts, with 28 of them (11 female, 39 percent) active in Q4. Of those citizen journalists active in Q4, five were new citizen journalists that did not write in the previous quarter regarding Papua issues. These levels of involvement are impressive, given the lack of a literary culture in many parts of the province and the fact that citizen journalists participate on a purely voluntary basis.

In Papua, citizen journalist reports continued to focus on health-care issues, including: budget cuts to HIV-related services at provincial level, *posyandu* services in villages, treatment support/drug adherence support for TB treatment, the need for transparency in health budgets, condom use as a method to prevent HIV infection, gender-based violence, as well as positive changes in the attitude of health workers in Mapuru Jaya Puskesmas. Citizen journalists have done an outstanding job of calling attention to challenges encountered by everyday people, and their honest and simple presentation of the material has earned praise from a number of readers.

After their training and subsequent activities, the group of citizen journalists in Mimika have received offers of additional support, including from stakeholders at Puskesmas Timika, which works with PT Freeport, to produce advocacy videos and informative written health outreach materials

Following the first citizen journalism training last year, PPMN provided refresher trainings sessions and mentoring for these citizen journalists. Given that not all journalists were able to attend the scheduled monitoring sections, PPMN's local facilitators visited each of the citizen journalists to provide further assistance. In addition, facilitators helped to link citizen journalists to the mainstream media. For example, through the local facilitator, the works of citizen journalists in Wamena were aired on RRI (a national radio channel).

To give the work of citizen journalists from Papua greater exposure, Forum Lenteng conducted film screenings, which were followed by group discussions, in all partner districts. The organization also showed films made by citizen journalists at the International Documentary and Experimental Film Festival in Jakarta on Sept. 17. This is expected to motivate the citizen journalists to produce more work, particularly about health services in Papua. The activity not only received a positive response from the audience, but Forum Lenteng received grants from the Ministry of Education to conduct a film screening in Sentani on Sept 23-24. Forum Lenteng supported citizen journalists in Kota Jayapura, and Mimika also received funding from BakTi in August 2014 to produce health features. It is important to notes that some of the citizen journalists, who were trained by PPMN and/or Forum Lenten, have actively participated in various multi-stakeholder forum activities and advocacy works.

Next Year

Kinerja will continue to support PPMN and Forum Lenteng to assist citizen journalists and mainstream media to cover health-related issues, as well as produce radio talk shows and features using follow-on grants.

3.4 Supporting Demand for Health Services - MSF Engagement

During FY 2014, Kinerja Papua's work with MSFs achieved rapid progress – from building or revitalizing these institutions from the ground up, to the point at which they were fully able to conduct their role to promote and advocate health service improvements both at the *puskesmas* and district level. With Kinerja Papua support, three IOs (YHI, Yukemdi, Yapeda) were later joined by Circle to strengthen *puskesmas*- and district-level MSFs that had been initiated by the program at the end of FY 2013. Over the next two quarters, MSFs in each *puskesmas* and district worked to map, promote and advocate health governance and health service issues at their respective levels. As of the end of FY 2014, MSFs began to discuss sustainability plans and ways in which to seek government endorsements as representatives of the community to further strengthen their organizational standing.

MSFs utilized both formal regular meetings and informal gatherings to conduct its roles and functions. Facilitated by the four IOs, these meetings were conducted in a variety of settings – including *puskesmas,* subdistrict offices, Bappeda offices, and members' houses – and involved local leaders as well as service providers. MSFs used these meetings to discuss their oversight roles, to map out local health service issues, and to prepare appropriate advocacy strategies. MSFs also actively promoted and discussed issues related HIV/AIDS, TB, MCH at the village level by using film as a medium. This strategy was particularly effective in overcoming low levels of literacy and in presenting material on health governance in an accessible manner. Whereas a number of films on technical health issues are readily available, an acute lack of available films related to health governance and health service issues became an obstacle. However, Kinerja Papua worked together with BaKTI to produce films on MCH Health Systems and MCH Service Standards.

During this reporting period, Kinerja Papua has seen a lot of MSF members playing important roles in disseminating health information in their local communities. Some of the members actively participated in film screenings and follow-up discussions at the village level. At the same time, religious leaders who actively participated in MSFs included health messages in their sermons as well as during individual visits to their congregation members. In addition, there has been an increase in communication related to HIV/AIDS, TB and MCH between

indigenous and religious leaders who are MSF members and key health officials at the district and *puskesmas* level.

MSF Meeting Agenda and Village Level Film Discussion

Districts	Meeting Agenda	Film Discussion
Jayapura	MSF objectives and roles, public participation and monitoring of health services, implementation of service-related SOPs at *puskesmas*, complaint handling mechanisms, HIV and TB-related service standard indicators, provision of incentives for TB cadres and development of TB village posts from village funds, information dissemination strategy on access to TB services and the importance of adherence to TB treatment	HIV/AIDS early detection service at *puskesmas*, stigma and discrimination against people living with HIV and TB, co-infection service at *puskesmas*, citizen rights to health service, adherence to TB and HIV treatments
Kota Jayapura	MSF objective and roles, *puskesmas* MCH services, public participation and monitoring of health services, provision of antenatal care services at *posyandu* and subsidiary *puskesmas* (*pustu*) level	Health service standards, public health insurance, *posyandu* and MCH, HIV/AIDS early detection service at *puskesmas*, stigma and discrimination against people living with HIV, antenatal care and medical check-ups during pregnancy, gender-based violence
Mimika	Health and public services, MCH and bidan siaga, MSF role and objectives, public participation and monitoring of health services, identifying active *posyandu* at village level, safe delivery campaign (information dissemination strategy), the need for services for patients with delivery complications from the villages	Health workforce absenteeism, drug availability, antenatal care and medical check-ups during pregnancy, early detection on pregnancy, immunization during pregnancy, gender-based violence
Jayawijaya	MSF role and obejctives, Public participation and monitoring of health services, *puskesmas* asset security issues, access to *puskesmas* subsidiary (*pustu*) and *posyandu* services	HIV/AIDS early dsetection service at *puskesmas*, VCT service at *puskesmas*, stigma and discrimination against people living with HIV, adherence to HIV and TB treatments, community support in TB treatment adherence

3.4.1 Complaint Surveys

As Kinerja Papua provided support for institutional capacity building, MSFs started to focus on designing and implementing complaint surveys during the second quarter of FY 2014. Both IOs and MSFs participated in complaint survey training and a series of workshops to map *puskesmas* service issues and to develop survey questionnaires. Following the training and workshops, community leaders and service providers interviewed survey respondents. At each *puskesmas*, more than 400 respondents were interviewed for a total of over 1,200 per district. Kinerja Papua facilitated a series of workshops and FGDs to analyze and to formulate the survey results into service charters to address issues at the *puskesmas* level and into technical recommendations for follow-up at the district level. Both of these documents are signed by representatives of the *puskesmas* and the DHO as service providers and are witnessed by the MSF and other stakeholders. In the case of Jayapura and Kota Jayapura, the district heads personally signed the documents, lending even more credibility to the process by which public input becomes government policy. In the last quarter of FY 2014, MSFs in each *puskesmas* also monitored the implementation of the service charter and reported the following results:

Service Charter Monitoring Results

District	Number of Commitments	Main Issues	Implemented
Kota Jayapura	33	Public health insurance (Jamkespa, BPJS) socialization. Outreach, health promotion and health services Human Resource Management (reward and punishment system for staff absenteeism) *Puskesmas* Service Standards (SOPs, service hours, patient care)	19 (58%)
Jayapura	60	*Puskesmas* infrastructure (water and sanitation) Outreach, health promotion and health services Human Resource Management (staff incentives) *Puskesmas* Service Standards (SOP, service hours, patient care)	57 (95%)
Mimika	45	MCH (Midwife and Traditional Birth Attendant Partnership) *Puskesmas* Service Standards (service hours, patient care, SOPs) MCH outreach, health promotion and health services Human Resource Management (reward and punishment system for staff absenteeism)	43 (96%)
Jayawijaya	22	Human Resource Management (reward and punishment system for staff absenteeism) Outreaching health promotion and health service Puskesmas Service Standard (service hour, patient care, SOP) Local language and security issues	14 (64%)

To see communities seize upon this opportunity to provide real input and get real responses within the span of a year is a landmark achievement in many localities. This is the first time in 67 years of independence that the people at the local level are able to openly criticize their government with a reasonable assumption of safety, security, and that things will change for the better.

In the coming year, Kinerja Papua will work to ensure the institutional strength and sustainability of MSFs continue to be enhanced. Kinerja Papua will encourage the four district governments to institutionalize MSF as Puskesmas Trustee Councils (*Dewan Penyantun Puskesmas*) and District Health Committees. Kinerja Papua has already obtained strong commitments from the head of the Jayapura DHO will work to attain the same levels of commitment from other districts. To ensure sustainability, Kinerja Papua worked with Circle to develop sustainability strategies for each MSF and their IOs (Yukemdi, Yapeda, YHI) that will be implemented in the months to come.

3.5 Cross-cutting issues

3.5.1 Minimum Service Standards (MSS)

As explained in the Kinerja Papua Annual Work Plan FY 2014, technical assistance in MSS aims to improve the capacity of local governments, particularly DHOs in the four supported districts, to apply MSS to health service management, especially to planning, budgeting, implementation and monitoring and evaluation at the local government and service unit levels.

The MSS technical assistance package includes the following activity phases:

1. Workshop for increasing awareness and political support to improve health MSS achievement;
2. Comparative study on Good Practices in adopting health MSS—particularly relevant to Kinerja packages in non-partner districts—and developing an action plan to adopt the MSS in these districts;
3. Update and verify data to calculate health MSS achievement;
4. Data system strengthening and assessment of MSS achievement;

5. Analysis of gaps in achieving MSS targets, prioritization of causes of such gaps, and strategies for addressing them;
6. Costing to reduce gaps and related strategies;
7. Integrating MSS targets and costing into local plan and budget documents;
8. Assessment/evaluation of MSS achievement;
9. Facilitating sharing of experience and information on good practices in applying minimum service standards at the provincial level.

The parameters used do measure success in health MSS technical assistance and the targets for each parameter are presented in the following table:

No	Parameter	Data Measured	Targets
1	MSS application in planning process	Number of districts/cities calculating costs of priority activities to achieve MSS (MSS Costing).	All Kinerja districts/cities have completed the Health MSS Costing
2	Utilization of activity prioritization results and/or MSS costing in a plan/budget document	Number of districts/cities utilizing activity prioritization results and/or MSS costing in budget negotiations	All Kinerja districts/cities have prepared their budgets based on the activity prioritization results and/or Health MSS costing
3	Annual MSS achievement evaluations	Existence/absence of annual MSS achievement evaluations	All Kinerja districts/cities conduct evaluations of Health MSS achievements at the end of each year or in quarter I of the following year.

The results of Kinerja technical assistance to its four partner districts in Papua as of the end of the end of September 2014 are described in the table below:

No	**Parameter**	**Kota Jayapura**	**Jayapura**	**Mimika**	**Jayawijaya**
1	MSS application in planning process (cost analysis has been completed)	✓	✓	✓	Completed at *puskesmas* level only
2	Utilization of activity prioritization results and/or MSS Costing in a plan/budget document.	✓	✓	×	Completed at *puskesmas* level only
3	Annual MSS achievement evaluations	Scheduled for Nov. 2014	✓	×	Scheduled for Nov. 2014 at *puskesmas* level only

Keeping in mind that technical support for MSS only began in May 2013, the levels of achievement reflected in the table above represent impressive progress.

Based on the status of achievements in each indicator as a result of MSS technical assistance in each partner district, it can be seen that the level of beneficiaries resulted in a prioritization of activities related to the key aspects of maternal and child health, TB and HIV/AIDS, and the integration of MSS cost analysis into planning and budgeting documents. However, the frequency with which MSS achievements are evaluated needs to be supported in order to capitalize on the sizeable potential available to fulfill the program's targets in this indicator.

In Jayapura, the MSS costing team, which comprises of DHO staff and MSF, completed the costing analysis in April and advocated the district administration for budget allocation. As a result, the district administration disbursed IDR 1 billion for MSS achievements using APBD 2014, or about 20 percent of the total budget that the MSS costing team (DHO staff and MSF) proposed – IDR 5 billion. This budget is about 5 percent of the total funds that the DHO received.

Following on the budget disbursement, the DHO evaluated the progress of the programs to achieve MSS in each puskesmas in August. The evaluation findings were used to revise the programs and develop work plans until 2017.

While in Kota Jayapura, the MSS costing team completed their costing analysis for 2014 to 2017 in Nov. 2013 and integrated the costing results into APBD 2014. Based on these costing results, the district administration disbursed IDR 1.2 billion or about 12 percent of the proposed budget – IDR 10 billion. In addition, the DHO receives IDR 3.4 billion from the special autonomy budget to meet MSS in health services.

Unlike the two districts above, Mimika shows slow progress in MSS implementation. Although the MSS team completed the cost analysis in July 2014, the DHO does not approve the cost analysis due to long discussions on the MSS costing among the health office staff. In order to overcome this challenge, Kinerja will conduct intensive communications with the DHO about the MSS.

Kinerja Papua has found the DHO in Jayawijaya to be largely uninterested in MSS costing at the district level, preferring instead to focus on service delivery units. Therefore Kinerja Papua joined forces with CHAI to support the development of action plans at all *puskesmas* in the district to not only measure gaps but to also complete the cost analysis of achieving MSS. As previously reported, Kinerja focused on MSS in frontline services while CHAI focused on those related to technical health issues. In early June, Kinerja Papua staff in Jayawijaya collaborated with DHO developed an instrument to asses/evaluate the MSS implementation at the *puskesmas*-level to measure the progress of MSS achievement in the district. This innovative instrument will be disseminated to other district partners and has potential to be promoted for provincial-level utilization.

In Jayawijaya, at least IDR 18 billion has been allocated in 2014 to finance the MSS implementation, where IDR 10 billion from Health Operational Fund (BOK) and Social Health Insurance Fund (BPJS), and IDR 8 billion from local budget of Jayawijaya. Kota Jayapura and Jayapura also succeed to allocate funding for MSS implementation in 2014 local budget with amount IDR 1.25 billion and IDR 1 billion, respectively, based on their MSS costing. Even though the proportion of allocated budget for MSS against the DHO budget ceiling is less than 25 percent, these achievements are valuable as starting points toward sustainable funding for MSS achievement.

Three key factors were responsible for outstanding progress in Jayapura and Kota Jayapura:

1. Strong commitment from the DHO and MSS team to conduct the whole MSS cycle, including cost analysis, budgeting, monitoring and evaluation.
2. DHOs have strong commitment to regularly updating their data, which meant that complete and accurate data on MSS achievements and an analysis of each cost unit was available at the DHO and *puskesmas*.
3. Multi-stakeholder forum involvement – comprised of representatives from the community, DHO, and *puskesmas* – was crucial. With training in MSS, they were better able to monitor the delivery of health services and lobby local government officials for improvements.

Next Year

Given that Kinerja will end in 2015, the program will focus at the district level on building the capacity of the DHO staff to evaluate their MSS programs and to integrate MSS costing results into district plans and budgets for 2015. The program will also work to strengthen the capacity of community members and the media to oversee MSS integration into the 2015 budget. Kinerja Papua will also seek to develop local government regulations on MSS implementation, monitoring and evaluation.

At the province level, Kinerja Papua will facilitate opportunities to share good practices and advocate for special autonomy funds to be used to achieve MSS.

3.5.2 Gender

In Q1, Kinerja Papua obtained USAID approval for two grantees – Yogyakarta-based *Lembaga Pengembangan Perepmuan dan Anak* (LSPPA) and *Yayasan Kesehatan Perempuan* (YKP) – to work on the issue of gender-based violence. Through these grantees, Kinerja Papua applied a three-pronged approach to address gender-based violence: By assisting local government to provide integrated services for women and children affected by violence based on MSS; by building capacity of health workers around the provision of health care in the context of gender-based violence; and by working with young people on adolescent reproductive health and healthy relationships (as a modification of the model Kinerja used to address underage marriage in Bondowoso to raise awareness on gender based violence).

Activities got underway in Q2 continued through the end of the year, sustaining the high levels of stakeholder support to take on the deeply embedded cultures of domestic abuse and alcoholism.

In this quarter, LSPPA assisted the District Office for Women Empowerment and Family Planning (BPPKB) in Kota Jayapura and Mimika to draft action plans to help prevent and to handle occurrences of gender-based violence, which were adopted in Q3. LSPPA also collaborated with Kinerja Papua partner *puskesmas* to building the capacity of health-care workers to treat and document cases of Violence against Women and Children (VAWC). With support from LSPPA, Puskesmas Tanjung Ria in Kota Jayapura and Puskesmas Mapurujaya in Mimika have become model centers for the treatment and documentation of VAWC, so that other health professionals can learn best practices in a real-world environment.

LSPPA's approach is unique in that it also focuses on economic empowerment and literacy training for survivors. These programs provide an opportunity for women to improve their position vis-à-vis their husbands and served as a forum from which a successful support group was then built. One participant in these groups has become a frequently sought-after resource for other victims seeking help, and a number of other members have taken up initiatives to raise awareness and educate their communities about the issue. This represents a small but important breakthrough in tackling the many taboos that have allowed VAWC, and domestic violence in particular, to continue.

The local governments and the community have both been supportive of LSPPA's initiative, which is groundbreaking in the region.

In FY 2014, the mayor of Kota Jayapura issued a formal decree that changed the structure of the P2TP2A (*Pusat Pelayanan Terpadu Pemberdayaan Perempuan dan Perlindungan Anak* or Integrated Service Centre for Women Empowerment and Child Protection) team to ensure the implementation of integrated services for victims of gender-based violence and domestic abuse.

In FY 2014, the mayor of Kota Jayapura formally established a P2TP2A team (*Pusat Pelayanan Terpadu Pemberdayaan Perempuan dan Perlindungan Anak* or Integrated Service Centre for Women Empowerment and Child Protection) thanks to the efforts of Kinerja Papua's IO. LSPPA will help to strengthening the existing P2TP2A through the development of referral mechanisms among government service providers including social workers, police, counselors and primary health-care providers, as it has done for the counterpart P2TP2A in Mimika. Political transitions and instability in Mimika, however, have slowed the pace of implementation from what had originally been hoped for.

This political instability also created delays for Kinerja IO YKP in its efforts to adapt adolescent reproductive health manual – originally developed for Kinerja's work in Bondowoso, East Java – to address gender-based violence in Mimika. As a result of initial training sessions, which were attended by 24 youths, YKP discovered that it had overestimated teenagers' basic understanding of the material and it had overlooked important differences regional attitudes that ultimately required a number of adjustments to the teaching material, visual aides and general approach. The peer-educator model used in Bondowoso was scrapped, and moving forward, future sessions will be offered by teachers who have already been trained on the material.

In line with the Bondowoso model, YKP also held a meeting for 50 religious and customary leaders to raise awareness about reproductive health issues and gender-based violence in order to build broader public support for the issues and in doing so, further improve maternal and child health and prevent the spread of HIV/AIDS.

Next Year

In FY 2015, Kinerja Papua will continue to support LSPPA to facilitate a series of meetings, discussions and consultations with key stakeholders to institutionalize SOPs and MSS for integrated services for victims of gender-based violence. These activities are expected to produce a comprehensive set of procedures for the variety of service providers involved, including the police, domestic abuse counselors as well as health-care workers.

Kinerja Papua will continue to work through YKP to disseminate the adolescent reproductive health manual, which was adapted from Kinerja's work in Bondowoso, East Java, as a preventative measure for addressing the culture of domestic violence present in Mimika.

4. Replication

Unlike in Main Kinerja, replication in Papua is defined as replication to other service delivery units within the same district, with less attention to replication to other districts through work at the provincial level. However, it is important to note, that many of Kinerja Papua activities, such as MSS cost analysis and SOPs training, focus on district-level stakeholders because of their potential for replication to other service delivery units within the district.

4.1 Knowledge Management of Good Practices

BaKTI is Kinerja's primary partner for the documentation and dissemination of good practices in Papua. It is important to note that in the first year, Kinerja Papua and its collaboration with BaKTI, focused on good practices from a variety of initiatives in Papua, even though they may not have resulted from the Kinerja program directly. Good practices identified were in the first place of a technical nature. There was little knowledge on governance-related good practices

and it would have been premature to focus on good practices in the first year of Kinerja Papua's implementation.

In its second year grant, BaKTI focused on documenting good practices that have arisen from Kinerja Papua interventions in its four partner districts, including the management of SOPs, implementation of MSS, complaint-handling mechanisms and MSFs.

In June, BaKTI began initial planning steps for the Good Practices Seminar, including identifying good practices for distribution to a wider audience. The good practices already agreed on include: complaint mechanisms, MSS costing, service unit MSFs, the gender-based violence intervention in Mimika and Kota Jayapura (run under LSPPA), and performance management and leadership training (run under PKMK-UGM). In light of the no-cost extension granted to the Kinerja Papua program, the seminar has been postponed to April 2015. This will allow for better documentation of good practices as they reach full maturity, and will allow the event to double as a project closing ceremony.

In Q4, PKMK UGM created a video tutorial that was shown during the Indonesian Public Health Policy Network in Bandung in September. The video documented five training topics, including: complaint handling mechanisms, technical guidance, internal *puskesmas* staff meetings, and SOP at both DHO and *puskesmas* level. The video has also been disseminated to PKMK UGM's training participants are there are plans to share it with non-partner *puskesmas* to support sustainability and wider replication of Kinerja's good practices.

In addition, BaKTi has created one videographic on the maternal and child health systems and one video on SOPs regarding regulated services for pregnant women at puskesmas. Thus far, the two videos have been shown during the Project Management Committee meeting in Jayawijaya, the Kinerja Papua IO Coordination meeting in September, and a number of events at the community level. The maternal and child health system video was also shown to members of DPRDs in Kinerja Papua partner districts.

Kinerja also made progress in documenting Kinerja good practices. In FY 2014, the Kinerja program formalized four good practices for replication or wider use by CSO. BaKTi is currently in the process of creating another four videos documenting the following Kinerja good practices: MSS Costing Integration; Complaint Mechanism; MSF in Health Service Unit levels; Integrated Services for Gender-based Violence Victims. Those good practices are scheduled to be finalized and disseminated to a wider audience in Q1 FY 2015.

4.2 Replication within Kinerja Districts

In FY 2014, Kinerja Papua supported replication related to Health Service Delivery Units' Planning in 15 non-partner *puskesmas*. Five of those *puskesmas* (one in Mimika and four in Kota Jayapura) adopted Kinerja Papua supported good practices in Q4, while the other 10 (all from Jayapura) adopted Kinerja's good practices earlier in FY 2014.

An important aspect of this success was Kinerja Papua's collaboration with the Clinton Health Access Initiative (CHAI) to assist a total of 13 *puskesmas* (including the three Kinerja partner *puskesmas*) in integrating MSS indicator targets and costing into work plans. The DHO also issued a formal decree stating that all service delivery units' work plans must be based on MSS target indicators and costing moving forward.

During the reporting period, Kinerja Papua good practices were institutionalized 27 times by non-partner puskesmas within the four partner districts. During Q4, good practices were

institutionalized 14 times, with 13 non-partner *puskesmas* in Jayawijaya (nine *puskesmas*), Jayapura City (three *puskesmas*) and Mimika (one *puskesmas*) forming their Proposed Plan of Work (RUK) for 2015 based on MSS Costing. In addition, one non-partner puskesmas in Jayapura City institutionalized Kinerja Papua health service delivery SOPs.

The formation of RUK was one of the topics at the PKMK UGM's training on Health Service Delivery Units' Planning supported by Kinerja Papua in Q3.

In Q4 FY14, three achievements were recorded for Indicator 21. PKMK UGM formed a video tutorial documenting five training topics that they covered throughout the project, including:

- Complaint handling mechanisms
- Technical guidance (*bimtek)*
- Internal *puskesmas* staff meeting (*minilok internal)*
- Cross-sectoral meetings (*minilok eksternal/pertemuan linsek)*
- SOP (both DHO and *puskesmas* level)

This video was shown by PKMK UGM during the Indonesia Public Health Policy Network (*Jaringan Kebijakan Kesehatan Indonesia – JKKI*) in Bandung in September 2014. The video has also been disseminated to PKMK UGM's training participants. There are additional plans to share this video with non-partner puskesmas to support sustainability and wider replication of Kinerja's good practices. In addition, BaKTi created videos on the Regional Health System (*SKD*) and on SOPs regarding required/regulated *puskesmas* services for pregnant women for the benefit of local communities and government staff in Papua. Thus far, the two videos have been shown during the Project Management Committee (PMC) meeting in Jayawijaya and shared during the Kinerja Papua IO Coordination meeting in September 2014.

4.3 Cooperation with Donors

As part of its participation in the general development context in Papua, Kinerja cooperates with other development partners operating in the area.

Kinerja Papua organized a provincial level development partners meeting with other development partners such as AIPD-AusAID and UN agencies at the request of the provincial Bappeda office. This meeting served two functions: To orient the newly elected governor and his administration to partners' work plans, and to coordinate support with local government work plans.

Cooperation with LPMAK and PT Freeport Indonesia in Mimika continued to make progress during this year. Kinerja Papua held discussions with both organizations and gained their support for the long-term action plan that the Mimika DHO designed, with Kinerja support, to reform the entire district health system. Kinerja Papua recommended a consultant to assist with implementation. Follow-on activities in Q3 include a workshop among district-level stakeholders to ensure congruence between the DHO's plans and the support from LPMAK and PT Freeport Indonesia.

Coordination and cooperation with other USAID programs also proceeded well throughout FY 2014.

The program met with the TB Cepat program coordinator to explore possibilities for collaboration or future involvement in the MSF initiated by Kinerja and SUM2 in Jayawijaya.

Kinerja also explored the possibilities for TB Cepat support in its work with cultural and religious institutions due to its previous experience and strong networks.

Coordination with SUM 1 and SUM 2 related to the preparation of monitoring and evaluation visit by the USAID HIV/AIDS team, both in terms of making contacts with related parties and in preparing necessary materials.

During this reporting period Kinerja also coordinated with AIPD Landasan, a project funded by the Australian Department of Foreign Affairs and Trade (DFAT) to synchronize project strategy and work plans, especially in the Jayapura district where both projects are active. The coordination meeting produced an intervention map between Kinerja, AIPD Landasan, CHAI, HCPI, and Unicef. The map should become a reference for all the parties in coordinating project strategy and activities.

Kinerja also continued to work with Unicef at the district level in Jayapura and at the provincial level, particularly related to synergizing technical assistance on MSS with Unicef's Investment Case approach.

As reported in an earlier section of this report, Kinerja Papua's LPSS in Jayawijaya collaborated with CHAI and with Unicef to support the development of action plans based on MSS at the *puskesmas* level to not only measure gaps in MSS achievement but to also complete corresponding cost analysis. CHAI also adopted SOPs developed by Kinerja to support the integration of HIV/AIDS services in Jayawijaya. Kinerja also coordinated with CHAI on the development of SOPs and work plans based on MSS achievement in all 13 *puskesmas* in the district.

Representatives from CHAI and Unicef have also served as resource persons for radio talk shows aired in Jayawijaya. Kinerja Papua and its media IOs plan to offer further opportunities for this type of collaboration in the coming quarter in order to enrich programming content as well as to allow other programs the chance to disseminate information on their particular areas of concern within the health sector.

These outcomes have been made possible through regular coordination meetings between the program and donors in Papua - SUM1, SUM2, UNICEF, CHAI and AIPD.

4.4 IO Capacity Development

IO capacity development remains a key part of the Kinerja Papua strategy. During the reporting period, Kinerja Papua IO CIRCLE Indonesia supported YHI, YUKEMDI and YAPEDA to assist MSFs in the conduct of complaint surveys, the facilitation of results analysis workshops and the drafting of service charters and technical recommendations.

CIRCLE also organized trainings on evidence-based advocacy for representatives from YHI, YUKEMDI and Kinerja-supported MSFs in Kota Jayapura and Mimika on May 15-17 and May 19-21, respectively. The training focused on practical examples from the field, and drew upon an analysis of political actors and agents of change to help draft actionable plans for the following months. A similar event was held in Q4 in Jayapura to strengthen the local MSFs and YAPEDA.

Finally, CIRCLE's activities during the reporting period helped to support the dissemination of monitoring tools for MSFs to use in tracking service charter fulfillment.

5. Project Management

5.1 Grants Management

During this reporting period, five new grants were approved by USAID and two grants were approved for cost extensions.

Three grantees – YUKEMDI, YAPEDA and YHI – requested a no-cost extension (NCE) for to December 2014, which have been approved in order to allow them to complete the remaining milestones and to finalizing final reports.

5.2 Cost Share

As described in the cost share chapter of the Kinerja Core report, the increasing number of development partners in Papua paying local governments for participation in their project activities, became a huge challenge for Kinerja to raise the initial committed 20 percent cost share contribution in Papua. At the same time the Kinerja Core program has reached a very mature stage, in which local governments see the benefit of working with the program and are readily allocating their funds. The program has also entered the stage of district-wide replication in the main program, and local government partners have allocated huge amounts of their own funding for project-related activities. For this reason, Kinerja had approached USAID to reallocate some of the Papua cost share obligations to the Kinerja Core program.

By the close of the year, Kinerja Papua had far exceed its annual target a majority of which was received through local government contributions. This figure brings the total cost share achieved since the program began to USD 2,370,388.09 or about 338 percent of the program's overall cost share obligation.

6. Challenges and Next Steps

As in the main Kinerja program, IO capacity remains a challenge in Kinerja Papua. The grant to CIRCLE Indonesia has gone very well, and with their support, the program's other IOs have shown tremendous progress. Building the capacity of local organizations is a long-term process and it is unrealistic to expect dramatic changes overnight. CSOs are often faced with competing priorities between developing in-depth technical expertise on a given issue, versus adapting to the interests of donors working in the region. Kinerja remains committed to helping its partners to succeed in developing sufficient levels of technical expertise to be well-positioned for future work in the field of health governance.

7. Monitoring and Evaluation

7.1 M&E Activities: Quarter 4, Fiscal Year 2014

In this quarter (July – September 2014), the Monitoring & Evaluation (M&E) team continued to work in close coordination with the Kinerja Papua program team to monitor and track progress against PMEP indicator targets. The M&E team conducted two spot check trips covering Kota Jayapura, Jayapura, and Jayawijaya. Additionally, both the M&E Specialist and Assistant attended several grantee and program-related meetings and events during this quarter, supporting the implementation of the Kinerja Papua program. Lastly, during this quarter the M&E team began the process of contracting data collection firms to complete the endline Organizational Capacity Assessment and Customer Satisfaction Survey. In August 2014, the

M&E Specialist conducted a spot check trip in Jayapura city and Jayapura district to verify achievements reported in Q3 FY14 for indicators 3, 8, 13, and 15 (indicators largely related to the Kinerja Papua supply side intervention). During this spot check trip, the M&E Specialist visited partner *puskesmas* and the District Health Office (DHO) in the two districts. Through interviews with heads of units, the M&E Specialist verified staff attendance in PKMK UGM trainings, medium-term action plans formed, and service charters and technical recommendations signed. The respondents also reported on the progress made with implementation of the medium-term action plans.

During the same month, the M&E Specialist travelled to Yogyakarta to meet with PKMK UGM and the Kinerja Papua Health Specialist. The M&E Specialist presented indicator achievements reported in Q3 FY14 related to PKMK UGM's activities and progress towards annual targets. Additionally, the Specialist orientated a new PKMK UGM staff who is in charge of compiling and sending online reports, informing her of the process and timeline.

In September 2014, the M&E Assistant also conducted a spot check in Jayawijaya for the same indicators. The Assistant met with the Head of Puskesmas Hom-Hom and Puskesmas Hubikosi and the main doctor in Puskesmas Musatfak, since head of the unit was not available. Through these interviews, the M&E Assistant verified *puskesmas* level medium-term action plans formed and the involvement of *puskesmas* in forming the service charters in collaboration with the MSFs.

In Q4 FY14, the M&E team also attended Kinerja Papua's IO Coordination and Quarterly Planning Meeting from September 17 - 19 held in Jayapura city. The M&E Specialist presented achievements made in the previous quarter, provided an overview of the progress against annual targets, and confirmed achievements reported for the current quarter. The Specialist also presented gaps towards annual targets to help guide the program team as they formed their work plan for the upcoming quarter. The meeting was attended by Kinerja Papua's implementing partners and field staff, as well as several of the national office staff including the Deputy Chief of Party (DCOP).

The M&E Specialist and Assistant also attended other Kinerja Papua meetings and events including those organized by Kinerja Papua's media implementing organizations:

- Forum Lenteng's citizen journalist film screening in Goethe Institute, Jakarta (July 18, 2014)
- PPMN's Orientation & Program Evaluation workshop for local media partners to launch their second year grant activities, held in Travellers Hotel, Jayapura district (1-2 September)

Lastly, the M&E team made progress with identifying data collection firms for endline data collection related to the Organizational Capacity Assessment (OCA) and the Customer Satisfaction Survey (CSS). The M&E team publically released three RFPs (request for proposal) during this quarter. Responses to the proposals were collected in September and were reviewed in October. The data collection firms for all data collection activities will be selected in the following quarter. Data collection will also take place in the following quarter, depending on the availability of capable data collection firms.

7.2 M&E Activities: Fiscal Year 2014

During FY 2014, the M&E team welcomed new team members, completed a PMEP revision, supported Kinerja Papua meetings, and completed spot checks. Lastly, the team prepared for endline data collection activities as explained above.

M&E Team Update

The Monitoring and Evaluation (M&E) team welcomed both a new M&E Specialist and M&E Assistant to the program. The M&E Specialist started on October 7, 2013 and is based in Jakarta. The M&E Assistant started on February 17, 2014 and is based in Jayapura city with the Kinerja Papua's Province field staff. The M&E Assistant's role is to support the Specialist on data collection and monitoring efforts.

Performance Management and Evaluation Plan (PMEP) Revision

Earlier this fiscal year, the M&E team completed a careful review of the PMEP version 3. The M&E Team Leader and Specialist discussed internally the definition and targets of each indicator and reconfirmed information with grantees, specifically those responsible for the supply side and media intervention outputs. The M&E Team Leader and the DCOP then completed PMEP version 4 and submitted it to USAID on November 26, 2013. In addition to the revised PMEP, the M&E team also submitted a formal response to the USAID reviewer's comments on PMEP version 3. Kinerja Papua received approval of the PMEP version 4 on January 6, 2014.

The M&E team subsequently translated and disseminated the approved PMEP version 4 in Bahasa Indonesia to the Kinerja program team in January 2014 during the IO Orientation meeting held in Jayapura city. In June 2014, the M&E Team Leader and Specialist submitted a revision of the PMEP version 4 to RTI specifically for replication indicators. The proposed revisions were submitted to USAID in July 2014. The revision of replication indicators was approved by USAID on August 18, 2014.

Kinerja Papua Quarterly Planning Meetings

The M&E team attended all Kinerja Papua's Quarterly Planning Meetings during this fiscal year. The quarterly meetings were generally attended by Kinerja Papua's implementing partners, Kinerja Papua's field staff, and national office staff, including the DCOP. Listed below are the Quarterly Planning Meeting dates for FY2014:

- December 16-18, 2013: Quarter 1 (October - December 2013)
- March 19-21, 2014: Quarter 2 (January – March 2014)
- June 18-22, 2014: Quarter 3 (April – June 2014)
- September 17-19, 2014: Quarter 4 (July – September 2014)

During the M&E sessions, the M&E team presented on reported achievements in the previous quarter, provided an overview of the progress against targets, and confirmed achievements that would be reported for the current quarter. The team also discussed reported achievements in one-on-one meetings with staff and grantees, and presented on gaps towards targets to help the program team form their work plan for the upcoming quarter.

In addition, during the Quarter 1 Planning Meeting, the M&E team trained all Kinerja Papua's field staff on the PMEP and presented the definitions for each performance indicator. The team carefully described the program logic, indicators of success, means of verification for all indicators, and fiscal year 2014 targets. In the Quarter 2 Planning Meeting, the M&E Specialist introduced the M&E Assistant and clarified the work division between the Specialist and Assistant. The M&E team also attended a specific session with the Kinerja Papua program team to discuss replication targets and strategy.

Spot Checks

In addition to the ongoing monthly data collection and verification through online and offline reports, the M&E Specialist and Assistant for Papua also conducted spot checks throughout the year in all four Kinerja Papua districts. Spot checks are done as part of quality assurance to verify, in-person, actual achievements towards reported achievements. Findings from the spot checks were reported to the M&E Team Leader and shared with the Kinerja Chief of Party (COP) and DCOP through an M&E Memo. The M&E Memo was also shared with relevant Kinerja Technical Specialists for follow-up actions. The M&E team drafted and shared three monitoring memos during the last fiscal year. Overall, the M&E team conducted a total of six spot checks within the four Kinerja Papua districts throughout fiscal year 2014 (November 2013, February 2014, August 2014, and September 2014).

In addition, Social Impact's Head Quarters conducted a routine spot check of data collected, verified, and reported by the Jakarta-based M&E team. Head Quarters randomly selected indicators and requested supporting documentation in May 2014. The spot check did not result in any significant findings.

7.3 Measuring Kinerja Papua's Achievements

In fiscal year 2014, the M&E Team recorded progress against performance indicator targets on a quarterly basis and analyzed causes for under and overachievement in relation to Kinerja Papua indicators. Out of the 22 indicators for the program, 20 indicators have FY14 targets. These include USAID governance indicators and Kinerja Papua activity indicators (including replication indicators). The two indicators without FY14 targets are related to the Organizational Capacity Assessment (OCA) and Customer Satisfaction Survey (CSS) assessments. Details on the progress of OCA and CSS assessment have been described in the section above.

In FY14, the Kinerja Papua program achieved its annual target for 18 indicators. The remaining two indicators are already more than 50% achieved. These achievements are reported in the Indicator Achievement Table (Annex B-1).

As seen in the program results framework in the PMEP, the Kinerja Papua program is broken down into three main sections, namely supply side interventions (Intermediate Result 1), demand side interventions (Intermediate Result 2), and replication of good practices to other service delivery units within partner districts (Intermediate Result 3). Progress made in FY14 will be described according to these three sections.

Supply Side

Kinerja Papua's supply side intervention is focused on improving health service delivery in partner DHO and *puskesmas* through the adoption of improved/best practices (Sub-Intermediate Result 1.1 and 1.2). A total of six indicators, including one USAID governance indicator, are used to measure progress against these results. All six targets (for both the fiscal year and program) for the associated indicators have been met.

Activities related to the supply side intervention include trainings for DHO and *puskesmas* staff. Trainings provided to strengthen local governments were mainly conducted by PKMK UGM.[26] Trainings in Jayawijaya were completed in Q4 FY14, while trainings in the other three districts were completed in Q3 FY14. The trainings focused on data management skills and

[26] PKMK UGM is the main grantee implementing Kinerja Papua's supply side intervention.

improving health service delivery units' planning process, encouraging them to form their budget and planning documents based on Minimum Service Standards (MSS) costing. In Q4 FY14, Kinerja Papua's Local Public Service Specialists (LPSS) staff in Jayapura also conducted two trainings focused on the formation of health service delivery Standard Operating Procedures (SOPs) and MSS costing integration. These trainings were follow-up trainings from those conducted in FY13. The follow-up trainings, however, focused more heavily on reaching non-partner units in the Kinerja Papua districts as part of the replication effort.

Overall, in FY14, a total of 197 participants (139 female, 71%) were considered trained in management skills and fiscal management (GJD 2.3.6). Outputs from these trainings are measured in other indicators described below.

One of the expected outputs from the Performance Management and Leadership (PML) trainings conducted by PKMK UGM in FY13 was an increased level of knowledge on performance management and leadership topics. A measurement of increased knowledge is done by comparing the pre- and post-training test scores of participants. Pre-test scores were reported in FY13 while post-test scores were reported in Q2 FY14 quarterly report. Of the 16 partner service delivery units (DHO and *puskesmas*) trained by PKMK UGM in 2013, 13 (81%) units increased their test scores (Indicator 7). This improvement is an indication that service delivery units have increased their knowledge of management and leadership topics contributing to Intermediate Result 1. The DHOs of Mimika, Puskesmas Dosay in Jayapura, and Puskesmas Limau Asri in Mimika had lower scores in their post-training test than their pre-training test. This decrease in test scores was most likely related to the low number of participants who attended the training.

Another major output from PKMK UGM trainings was the formation of action plans. During FY14, partner health service units formed their medium-term action plans after attending the two trainings on data management and *puskesmas* planning. A total of 113 medium-term action plans were produced in FY14 by the DHO and partner *puskesmas* in four Kinerja Papua districts (Indicator 8). While several medium-term action plans were follow-up plans from incomplete short term action plans, most new plans were focused on improving the capacity and performance of health unit staff. Examples of medium-term action plans produced are included below:

- Present a request to the DHO for additional staff, specifically for one dentist, one official in charge of sanitary issues, and one nurse (from Puskesmas Abepantai, Kota Jayapura)
- Send health unit staff for further schooling (from DHO of Jayapura)
- Form partnerships between traditional birth attendants and medically trained midwives (from Puskesmas Mapurujaya, Mimika)
- Offer technical guidance on financial allocation for the treasury department in health service units (from DHO of Jayawijaya)

Monitoring of the implementation of these medium term action plans was then conducted and reported in Q4 FY14. At the DHO level, a total of 25 out of 28 medium-term action plans were implemented (Indicator 9). Of the 25 implemented plans, 20 were "completed" and five were "partially completed". Meanwhile, at the health service delivery unit level, a total of 73 out of 85 medium-term action plans were implemented (Indicator 10). Of the 73 plans, 65 were "completed" and eight were "partially completed". The implementation of these action plans at the health service delivery unit/puskesmas level has directly contributed to the

institutionalization of improved practices by service delivery units (Sub-Intermediate Result 1.2). Furthermore, the implementation at the DHO level has contributed towards the adoption of improved practices supported and enabled by DHO (Sub-Intermediate Result 1.1).[27]

Examples of implemented medium-term action plans in Q4 FY14 include:

- Training for the Development of Active Standby Villages (*Kampung Siaga Aktif*) in DHO of Kota Jayapura[28]
- Installment of loudspeakers in the waiting room in Puskesmas Dosay of Jayapura
- Formation of a Community Complaint Handling Team (*Tim Pelaksana Pengaduan Masyarakat – P3M*) in Puskesmas Timika of Mimika
- Establishing a SOP for the use and maintenance of the ambulance in Puskesmas Hubikosi of Jayawijaya

Overall, during fiscal year 2014, a total of 49 action plans were implemented by the DHOs in four Kinerja Papua districts. These comprise 24 short-term action plans implemented in Q1 FY14 and 25 medium-term action plans implemented in Q4 FY14 (Indicator 9). Meanwhile, on the *puskesmas* level, a total of 144 action plans were implemented by partner *puskesmas* in the four districts during FY14. These comprise 71 short-term action plans implemented in Q1 FY14 and 73 medium-term action plans implemented in Q4 FY14 (Indicator 10).

In addition to PKMK UGM's activities, Kinerja Papua's LPSS also contributed to progress in the supply side intervention by advocating for the adoption of improved practices by DHOs (Sub-Intermediate Result 1.1). In Q4 FY14, the M&E team documented two formal letters issued by the DHOs in Jayapura and Jayawijaya to run the trial phase of the performance logbook system for contract doctors in their respective districts. The four DHOs of Kinerja Papua districts have also formally adopted MSS costing and indicator targets into their district planning and budgeting system. In Jayawijaya, the Head of DHO also signed SOPs related to public health service delivery instructing all *puskesmas* in the district to implement them. The signed SOPs include procedures regarding:

- ANC (Antenatal Care) K1 services
- Provider-Initiated HIV Testing and Counseling (PITC) services
- Prescription and provision instructions on dosage of drugs

Other improved practices adopted by the DHOs include the formal establishment of a P2TP2A team in Kota Jayapura through a formal decree (*Surat Keputusan – SK*) issued by the Mayor.[29] Overall, in FY14 Kinerja Papua supported management systems were adopted or institutionalized six times within the four partner districts (Indicator 6).

---

[27] Apart from regular monitoring by the local PKMK UGM staff in each of the four districts, staff from the Training Center for Health Workers (*Balai Latihan Tenaga Kesehatan – Balatkes)* also conducted their own monitoring and evaluation activities from June - July 2014. *Balatkes* staff travelled to the four Kinerja Papua districts and visited partner *puskesmas* and DHO in person to verify progress made towards the medium-term action plans. Results of the *Balatkes* monitoring and evaluation activities have been saved by the M&E Team as part of the supporting documents for achievements reported under Indicators 9 and 10.

[28] *Kampung Siaga Aktif* are villages whose residents have the resource and capability as well as willingness to prevent and overcome health issues, disasters and health emergencies independently. It is also one of the indicators measured in the national health MSS.

[29] P2TP2A stands for *Pusat Pelayanan Terpadu Pemberdayaan Perempuan dan Perlindungan Anak* - Integrated Service Centre for Women Empowerment and Child Protection.

Demand Side

Progress has also been made in Kinerja Papua's demand side intervention in this fiscal year. The program's demand side intervention is focused on creating/strengthening incentives for public engagement in the provision of local health services (Intermediate Result 2). Based on the Results Framework, this is achieved by having mechanisms for service user and citizen engagement in place (Sub-Intermediate Result 2.1) and by disseminating information on local government responsibilities and performance (Sub-Intermediate Result 2.2). A total of nine indicators, including one USAID governance indicator, are used to measure progress against this result. All nine indicators met annual and program targets at the end of FY14.

Mechanisms for service users and citizen engagement were established through the formation of 16 multi-stakeholder forums (MSFs) in the four districts in Q1 FY14 (Indicator 12). Through these multi-stakeholder forums, Kinerja Papua was able to engage civil society in health system oversight (GHI 1.2.2.2). Members of MSFs vary in each district but generally include key community figures (such as members of religious groups) and staff from respective health service delivery units. MSFs meet at least once a month and discuss issues related to public health service delivery and other relevant health issues.

To be considered active, MSFs need to provide regular oversight of health service delivery in Kinerja Papua districts. As defined by the program team, active oversight and advocacy includes regular MSF meetings discussing public health service delivery issues (Indicator 11). All 16 MSFs established in the four Kinerja Papua areas have played a key role in disseminating complaint surveys, forming service charters and technical recommendations in collaboration with health service delivery unit staff, as well as monitoring the implementation of service charters.

In FY14, a total of 12 service charters were produced and signed in four Kinerja Papua districts (Indicator 13). Twelve technical recommendations in response to the complaint survey results were also produced by Kinerja Papua's partner health units in four districts (Indicator 15). Both service charters and technical recommendations were signed by the Head of MSFs, Head of partner *puskesmas,* and Head of DHO. Formal signing ceremonies were held in Jayapura city and district. The US Ambassador, Mr. Robert Blake, was able to attend and witness the signing of the service charters and technical recommendations in Jayapura district in early June 2014.

The implementation of the service charters were monitored by the MSFs in Jayapura city, Mimika, and Jayapura district during Q4 FY14. A total of 123 promises addressing complaints were fulfilled in these three districts (Indicator 14). *Puskesmas* level MSFs monitored *puskesmas* promises by visiting and interviewing *puskesmas* staff. Examples of promises fulfilled include putting up signs prohibiting visitors to spit carelessly or bring animals to the *puskesmas,* and ensuring that staff attend to patients based on their queue number. Below is a breakdown of the number of promises fulfilled per district:

- Jayapura : 58 out of 63 promises
- Kota Jayapura : 20 out of 33 promises
- Mimika : 45 out of 47 promises

Other activities under the demand side intervention include the dissemination of information on local government responsibilities and performance. These activities were mainly done through engagement with local media organizations (Sub-Intermediate Result 2.2). The two

main Kinerja Papua media IOs are PPMN and Forum Lenteng.[30] During this quarter, MOUs were signed between PPMN and two new media outlets based in Papua, namely Rock FM and Radio Suara Kasih Papua (RSKP) (Indicator 16). Rock FM replaced RRI Jayapura, who had been PPMN's local radio partner in Jayapura city previously, while RSKP replaced Radio Kenambai Umbai, who had been PPMN's local radio partner in Jayapura district previously. Overall, in FY14 there were a total of 34 media outlets providing regular programming or dissemination activities related to health issues. Partnerships built with these local media outlets contribute directly towards the establishment of mechanisms for service users and citizen engagement (Sub-Intermediate Result 2.1).

Both PPMN and Forum Lenteng also work closely with the local communities to build their capacity as active citizen journalists reporting on local government performance. In Q4 FY14, 28 citizen journalists (11 female, 39%) from PPMN and Forum Lenteng reported on local government performance and/or provided health information in the four Kinerja Papua districts. Of the 28 active citizen journalists in this quarter, 5 were new citizen journalists (Indicator 17). Overall, in FY14 a total of 70 active citizen journalists were trained or mentored by PPMN and Forum Lenteng.

Products created by the local media outlets and citizen journalists 'directly contribute to disseminating information on local government responsibilities and performance (Sub-Intermediate Results 2.2). In Q4 FY14, 73 additional media products were produced by PPMN and Forum Lenteng. Of the 73 media products, 64 were articles and photo essays written by PPMN and Forum Lenteng's citizen journalists. The remaining nine achievements were three PSA recordings, four radio talkshows, and two feature articles published by Cendrawasih Post.[31] Overall in FY14, a total of 563 media products were produced, including 338 citizen journalist products (Indicator 18). Other media products include talkshows and PSA recordings aired by local radio stations, health features created by local TV media outlet, and health articles published in print media outlets. Topics covered by these products ranged from information related to Kinerja Papua's health issues such as services available for HIV/AIDS positive patients in Jayapura city to commentaries on the services provided by *puskesmas* such as the lack of manpower in *puskesmas* in Mimika.

Replication

Although Kinerja Papua only provides direct support to three *puskesmas* in each of the four partner districts, the program does aim to have Kinerja-supported good practices replicated in other *puskesmas* within the districts (Intermediate Result 3). In Q4 FY14, Kinerja Papua-supported practices were institutionalized 14 times by non-partner *puskesmas* within the four partner districts. In total for FY14, good practices were adopted 27 times by non-partner units (Indicator 19). Practices replicated in FY14 were the institutionalization of public health service delivery SOPs supported by Kinerja Papua and the integration of MSS costing in

[30] To carry out its activities, PPMN partners with media outlets based in Papua such as local radio stations or print media outlets. As for Forum Lenteng, they partner with local organization in each of the four districts to establish media centers for training and mentoring citizen journalists, as well as to provide a venue for the trained individuals to continue producing media products.

[31] *Cendrawasih Post* is a daily local newspaper based in Jayapura city.

district budget and planning documents [specifically *puskesmas* POA (Plan of Action) and Proposed Plan of Work (*Rencana Usulan Kerja – RUK)*].

These practices were replicated by a total of 15 non-partner *puskesmas* in Jayawijaya, Kota Jayapura, and Mimika (Indicator 20). The 15 non-partner *puskesmas* are comprised of nine in Jayawijaya, three in Kota Jayapura, and one in Mimika. By definition, replication *puskesmas* do not receive direct implementation support from Kinerja Papua but are invited to attend program trainings, such as formation of SOPs and integration of MSS costing.

Documentations of good practices were disseminated in Q4 FY14 (Sub-Intermediate Result 3.1). The annual target for FY14 is four formalized good practices for replication/wider use by Indonesian civil society organizations (Indicator 21). The M&E team documented three achievements in this FY, almost meeting the target for FY14 (75%).

PKMK UGM formed a video tutorial documenting five training topics that they had covered throughout the Kinerja program, which include:

- Complaint handling mechanisms
- Technical guidance (*bimtek*)
- Internal puskesmas staff meeting (*minilok internal*)
- Cross-sectoral meetings (*minilok eksternal/pertemuan linsek*)
- SOP (both DHO and puskesmas level)

This video was shown by PKMK UGM during the Indonesia Public Health Policy Network (*Jaringan Kebijakan Kesehatan Indonesia – JKKI*) in Bandung in September 2014. The video was also disseminated to PKMK UGM's training participants.

In addition, Bakti also formed one videographic on the Regional Health System (*Sistem Kesehatan Daerah - SKD*) and one video on SOPs regarding required/regulated services for pregnant women in *puskesmas*. The target audiences for these two videos are local communities and government staff in Papua. Thus far, the two videos have been shown during the Project Management Committee (PMC) meeting in Jayawijaya, shared during the Kinerja Papua IO Coordination meeting in September 2014, and posted on the PPMN citizen journalists' Facebook page.

7.4 Lessons Learned and Steps Forward

In this quarter, through feedback from the implementing organization PKMK UGM, the M&E team recognized the need to conduct in-person meetings with their staff at least once a quarter to simplify the process of aggregating and verifying data. Hence, the M&E Specialist together with the Kinerja Papua Health Specialist scheduled a trip to Yogyakarta in August 2014 for a one-day meeting with PKMK UGM. In the meeting, the team discussed reported achievements and outstanding documentations as well as their workplan for that quarter. The M&E team will schedule a similar one-day meeting with the IO early next quarter to verify achievements attained in fiscal year 2014 and clarify plans for the upcoming quarter.

During this fiscal year, the M&E team also recognized the need for in-person clarification and guidance on the evidence required for PMEP indicators to the Kinerja Papua field staff. Aside from one-on-one meetings with the field staff, the M&E team provided training during the Kinerja Papua Quarterly Planning Meeting in December 2013 on the PMEP, Kinerja Papua's Result Framework, indicators related to grantees and field staff activities, and acceptable means of verification. The M&E team then translated the PMEP into Bahasa Indonesia, which was

finished and distributed to the Kinerja Papua field and national office staff in March 2014. The Bahasa Indonesia PMEP proved to be useful in clarifying indicator definitions and means of verification especially to Kinerja field staff.

Lastly, the M&E team learned from the difficulties faced in contracting good data collection firms for data collection in Papua. Though the RFPs for three data collection activities were released in Q4 FY14, only two sufficient proposals were received. The M&E team has learned from this situation and is developing additional options for data collection mediums in the following quarter.

In the upcoming quarter, as the majority of the indicator targets have been met, the M&E team will focus on collecting data for the two indicators that are still not 100% achieved. The team will also focus on providing monitoring and oversight of the selected and contracted data collection firms for three data collection activities (OCA, CSS, and qualitative). The team will first focus on contracting firms in October and will then focus on monitoring and oversight of selected firms in November and December (Q1 FY15). The M&E team will receive and review final data reports in December and utilize results for analysis of progress in Papua in January and February 2015 (Q2 FY15).

Annex B-1: Kinerja Papua Performance Monitoring and Evaluation Plan Achievement[32]

Current Reporting Period: Fiscal Year 2014 (October 2013 - September 2014)[33]

NO.	INDICATOR NAME	BASELINE	FY14 TARGET	FY14 ACHIEVEMENT				FY14 TO DATE	PROGRAM TARGET	PROGRAM TO DATE	REMARKS FOR CURRENT REPORTING PERIOD
				Q1	Q2	Q3	Q4				
USAID Governing Justly and Democratically (GJD) Indicators											
1	GJD 2.2.3-3: Number of local mechanisms supported with US Government assistance for citizens to engage their subnational government	0	28	16	16	22	28	28 (100%)	28	28 (100%)	"Local mechanisms", in the Kinerja Papua context, relate to multi-stakeholder forums (MSFs) and service charters. In Q4 FY14, Kinerja partner health units in Mimika and Jayawijaya have finalized and signed six service charters (three respectively per district). These service charters were based on the complaint survey results disseminated in the previous quarter. See Indicator 13 for more detailed information regarding the service charters. Overall, Kinerja Papua has met 100% of its annual and program target. The 28 achievements for this indicator are comprised of 16 MSFs and 12 service charters that were formed in the four Kinerja Papua districts in FY2014.

[32] Indicators reported in this table are based on Kinerja Papua PMEP v.4, which was approved by USAID on January 6, 2014. Indicator achievements noted per quarter reflect data and evidence received during that quarter. Totals per quarter do not necessarily reflect program achievements in that quarter.

[33] Final totals are based on the M&E Indicator Database, October 14, 2014.

NO.	INDICATOR NAME	BASELINE	FY14 TARGET	FY14 ACHIEVEMENT				FY14 TO DATE	PROGRAM TARGET	PROGRAM TO DATE	REMARKS FOR CURRENT REPORTING PERIOD
				Q1	Q2	Q3	Q4				
2	GJD 2.2.3-4: Number of local non-governmental and public sector associations supported with US Government assistance	0	19	11	14	14	15	15 (79%)	19	15 (79%)	In Q4 FY14, PPMN (one of Kinerja Papua's media implementing organizations - IO) received a cost-extension until 31st December 2014. The provision of a second year grant to PPMN has been counted as an achievement for this quarter. During this quarter, four IOs did receive a no-cost extension (NCE), though these are not counted as achievements because no additional funding was provided by the US Government. The NCE details for this quarter are included below: • Forum Lenteng – extended until 30th September 2014 • YHI – extended until 30th September 2014 • Yapeda – extended until 31st December 2014 • Yukemdi – extended until 15th October 2014 Overall, in FY2014, a total of 15 local non-governmental and public sector associations have received assistance from the US government. For this indicator, Kinerja Papua has met 79% of its annual and program target. The program target of 19 is based on the assumption that six of the IOs would be given a cost-extension (2nd year) grant. By the end of FY14, however, only three IOs were given a second-year grant while the remaining three received a NCE. The four NCE IOs from this quarter may receive a cost-extension in Q1 FY15.

3	GJD 2.3.6: Number of individuals who received US Government-assisted training, including management skills and fiscal management, to strengthen local government	0	152	0	0	77	197	197 (130%)	152	197 (130%)	A total of 197 participants (139 female, 71%) were noted as "trained" in FY14. In FY2014, Kinerja Papua overachieved the annual and program target (130% over the target of 152 trained individuals). The participants are those who attended two PKMK UGM trainings as well as those who attended the additional SOP and SPM trainings in Jayapura conducted by Kinerja. The details of these trainings are included below: **PKMK UGM Training:** Of the 197 trained participants, 116 participants (84 female, 72%) were specifically trained by PKMK UGM. The participants were from partner and non-partner puskesmas and were considered "trained" if they met the definition below: • Attended 50% of the total training days for each training, and • Attended two out of the four trainings By the end of FY2014, PKMK UGM has conducted two out of the four trainings planned for this fiscal year in four Kinerja Papua districts. The two trainings conducted in FY2014 were "Improvement of Data Collection and Processing Systems" and "Health Service Delivery Units' Planning". The remaining two trainings will cover different topics per district specific to district needs and are scheduled to be conducted between October and November 2014. The delay of these trainings was due to a late start of PKMK UGM's second year grant, which only started on the 1st of February 2014. Local political issues also caused challenges in finalizing schedules of trainings, especially considering the high turnover within service unit staff after the legislative election in April 2014. **Kinerja Training:** In addition to the "trained" participants from the two PKMK UGM Trainings in this fiscal year, 81 participants (55 female, 68%) from the SOP and MSS Costing trainings conducted by Kinerja Papua LPSS staff in Jayapura are also considered "trained". These SOP and MSS Costing trainings were similar to the trainings conducted in FY2013. They were, however, more specifically targeted towards non-partner *puskesmas* in Kinerja Papua partner districts. The participation of non-partner *puskesmas* became a higher priority in FY2014 to ensure that replication occurs before the end of the Kinerja Papua program. As a result of these trainings, some of the non-partner *puskesmas* have replicated Kinerja Papua good practices (see Indicator 19 and 20 for further details).

NO.	INDICATOR NAME	BASELINE	FY14 TARGET	FY14 ACHIEVEMENT				FY14 TO DATE	PROGRAM TARGET	PROGRAM TO DATE	REMARKS FOR CURRENT REPORTING PERIOD
				Q1	Q2	Q3	Q4				
Global Health Indicator											
4	GHI 1.2.2.2: Number of districts engaging civil society in health system oversight	0	4	4	4	4	4	4 (100%)	4	4 (100%)	In FY2014, MSFs established in the four Kinerja Papua areas played a key role in disseminating complaint surveys, forming service charters and technical recommendations in collaboration with health service delivery unit staff, as well as monitoring the implementation of service charters. See indicator 14 for further details on monitoring results by the MSF for the implementation of service charters. Overall, Kinerja Papua has met 100% of its annual and program target of four districts engaging civil society in health system oversight. Kinerja Papua's partner districts are Jayapura, Jayawijaya, and Mimika and Jayapura city.
Performance Indicators											
5	Score of Organization Capacity Assessment (OCA)	-	n/a					n/a	50%	n/a	The baseline score was reported in the PMEP v.4, together with the performance target. Kinerja believes that at least 50% of the organizations assessed in the OCA will improve their score during the Kinerja Papua program implementation period (meaning partner organizations have improved in the areas of responsiveness, accountability, transparency, or participation). The final score will be reported at the end of the project, after end-line Organizational Capacity Assessment is conducted in Q1 FY15. The total possible score for the OCA is 112.
	District Health Office of Kota Jayapura	75.1	n/a					-	-	-	
	District Health Office of Jayapura	86.8	n/a					-	-	-	
	District Health Office of Jayawijaya	61.2	n/a					-	-	-	
	District Health Office of Mimika	80.1	n/a					-	-	-	
	Puskesmas Tanjung Ria	76.5	n/a					-	-	-	
	Puskesmas Abe Pantai	75.5	n/a					-	-	-	
	Puskesmas Koya Barat	76.8	n/a					-	-	-	
	Puskesmas Sentani Kota	76.4	n/a					-	-	-	
	Puskesmas Dosai	79.8	n/a					-	-	-	
	Puskesmas Depapre	85.1	n/a					-	-	-	
	Puskesmas Homhom	62.5	n/a					-	-	-	
	Puskesmas Musatfak	62.9	n/a					-	-	-	
	Puskesmas Hubikosi	56.3	n/a					-	-	-	

NO.	INDICATOR NAME	BASELINE	FY14 TARGET	FY14 ACHIEVEMENT				FY14 TO DATE	PROGRAM TARGET	PROGRAM TO DATE	REMARKS FOR CURRENT REPORTING PERIOD
				Q1	Q2	Q3	Q4				
	Puskesmas Mapuru Jaya	77.6	n/a					-	-	-	
	Puskesmas Limau Asri	63.3	n/a					-	-	-	
	Puskesmas Timika Kota	76.1	n/a					-	-	-	
6	Number of Kinerja supported management systems that are adopted or institutionalized by local governments	0	8	2	3	6	8	8 (100%)	8	8 (100%)	Two management systems were documented as "adopted or institutionalized" in Q4 FY14. In Jayapura and Jayawijaya, the District Health Office (DHO) adopted the performance logbook system for contract doctors. In Jayapura, the DHO issued a formal decree (*Surat Keputusan – SK),* while in Jayawijaya, the DHO issued a circular letter (*Surat Edaran – SE)* instructing the implementation of the trial phase for the logbook system. Mimika and Jayapura city have plans to trial this logbook system, although formal documentation from the DHO have not been issued. For this indicator, Kinerja Papua has met 100% of its annual and program target. A total of 8 Kinerja supported management systems were adopted by local governments since the program launched including MSS Costing integration in local budget planning in the four districts, SOPs regarding public health service delivery in Jayawijaya, formation of a team for the Integrated Service Centre for Women Empowerment and Child Protection (P2TP2A) in Jayapura city, and two formal letters issued by the DHO regarding the performance logbook system for contract doctors.
7	Average Score of training test	-	50%					81% (162%)	50%	81% (162%)	The baseline measurement was conducted at the beginning of PKMK UGM's training in April 2013. Results of the post-test training were received by Kinerja's M&E team in January 2014. A majority (81.25%) of the Kinerja service units – DHO and *puskesmas* - increased their post-test scores, indicating an increase in knowledge of management and leadership topics. Out of the 16 service units that Kinerja Papua supported, three units received a lower post-test score than their pre-test score, namely DHO Mimika, Puskesmas Dosai and Puskesmas Limau Asri. According to PKMK UGM, the lower post-test score results for these three Kinerja units relate to their low number of participants in the Kinerja training and the low capacity of the units themselves.
	District Health Office of Kota Jayapura	35.78	n/a					42.85	n/a	42.85	
	District Health Office of Jayapura	32.14	n/a					35.15	n/a	35.15	
	District Health Office of Jayawijaya	30.50	n/a					37.13	n/a	37.13	
	District Health Office of Mimika	32.00	n/a					31.27	n/a	31.27	
	Puskesmas Tanjung Ria	30.00	n/a					40.13	n/a	40.13	
	Puskesmas Abe Pantai	30.00	n/a					42.00	n/a	42.00	
	Puskesmas Koya Barat	41.63	n/a					43.25	n/a	43.25	

NO.	INDICATOR NAME	BASELINE	FY14 TARGET	FY14 ACHIEVEMENT				FY14 TO DATE	PROGRAM TARGET	PROGRAM TO DATE	REMARKS FOR CURRENT REPORTING PERIOD
				Q1	Q2	Q3	Q4				
	Puskesmas Sentani Kota	31.92	n/a					42.09	n/a	42.09	The annual and program target for this indicator is 50% of the partner service delivery units (DHO and Puskesmas) with increased average scores of their training test. Kinerja Papua has met and exceeded this target, as 81% of their partner service units have increased post-test scores after attending the Kinerja supported trainings conducted by PKMK UGM.
	Puskesmas Dosai	35.60	n/a					34.60	n/a	34.60	
	Puskesmas Depapre	27.13	n/a					34.00	n/a	34.00	
	Puskesmas Homhom	31.00	n/a					42.17	n/a	42.17	
	Puskesmas Musatfak	27.75	n/a					35.33	n/a	35.33	
	Puskesmas Hubikosi	27.20	n/a					33.86	n/a	33.86	
	Puskesmas Mapuru Jaya	30.00	n/a					35.44	n/a	35.44	
	Puskesmas Limau Asri	33.50	n/a					26.00	n/a	26.00	
	Puskesmas Timika Kota	30.67	n/a					42.89	n/a	42.89	
8	Number of Kinerja Papua-supported action plans produced	0	48	0	0	113	113	113 (235%)	96	214 (223%)	No additional achievements were recorded in Q4 FY14, as health service delivery units were focused on implementing medium-term action plans formed in the previous quarter. In FY2014, a total of 113 medium term action plans were produced and finalized by the health service units and district offices in the four Kinerja Papua districts. Overall, Kinerja Papua has met 235% of its annual target of 48 medium-term action plans. Kinerja Papua has also met 223% of its program target of 96, which is an aggregate of both short-term and medium-term action plans. A total of 214 action plans have been formed throughout the program, comprising 101 short term action plans produced in FY13 and 113 medium term action plans produced in FY14. There was significant overachievement for this indicator for FY14 because there were only three action plans targeted per service unit in the PMEP v. 4. The units, however, developed multiple short term and medium term action plans.

NO.	INDICATOR NAME	BASELINE	FY14 TARGET	FY14 ACHIEVEMENT				FY14 TO DATE	PROGRAM TARGET	PROGRAM TO DATE	REMARKS FOR CURRENT REPORTING PERIOD
				Q1	Q2	Q3	Q4				
9	Number of Kinerja Papua-supported action plans implemented by District Health Office	0	12	24	24	24	49	49 (408%)	12	49 (408%)	In Q4 FY14, the DHO in the four Kinerja Papua districts implemented 25 out of 28 DHO medium term action plans formed in Q3 FY14. Of the 25 plans, 20 were "completed" and 5 were "partially completed". A total of 49 action plans have been implemented by DHO in the four districts in FY2014. The 49 action plans are comprised of 24 short-term action plans implemented in Q1 FY14 and 25 medium-term action plans implemented in Q4 FY14 (noted above). Overall, Kinerja Papua has met its annual and program target of 12 action plans implemented by the DHO. There is significant overachievement for this indicator because the target was set based on the assumption that each Kinerja-supported DHO would develop 3 short term and 3 medium term action plans, through the support of Kinerja's partner organization PKMK UGM. It was estimated that 50% of the action plans would be completed (12 as the target for FY14) during the Kinerja Papua program. As seen in Indicator 8, however, units have developed more than 3 short-term and 3 medium-term action plans. This has led to significant overachievement for Indicator 9.

NO.	INDICATOR NAME	BASELINE	FY14 TARGET	FY14 ACHIEVEMENT				FY14 TO DATE	PROGRAM TARGET	PROGRAM TO DATE	REMARKS FOR CURRENT REPORTING PERIOD
				Q1	Q2	Q3	Q4				
10	Number of Kinerja Papua-supported action plans implemented by *puskesmas*	0	36	71	71	71	144	144 (400%)	36	144 (400%)	In Q4 FY14, partner *puskesmas* in the four Kinerja Papua districts implemented 73 out of the 85 *puskesmas* medium term action plans formed in Q3 FY14. Of the 73 plans, 65 were "completed" and 8 were "partially completed". A total of 144 action plans have been implemented by partner *puskesmas* in the four districts in FY2014. 144 action plans comprises of 71 short-term action plans implemented in Q1 FY14 and 73 medium-term action plans implemented in Q4 FY14. Overall, Kinerja Papua has met 400% of its annual and program target of 36 action plans implemented by the *puskesmas*. There is significant overachievement for this indicator because the target was set based on the assumption that each Kinerja-supported *puskesmas* would develop 3 short term and 3 medium term action plans, through the support of Kinerja's partner organization PKMK UGM. It was estimated that 50% of the action plans would be completed (36 as the target for FY14) during the Kinerja Papua program. As seen in Indicator 8, however, units have developed more than 3 short-term and 3 medium-term action plans. This has led to significant overachievement for Indicator 10.

NO.	INDICATOR NAME	BASELINE	FY14 TARGET	FY14 ACHIEVEMENT				FY14 TO DATE	PROGRAM TARGET	PROGRAM TO DATE	REMARKS FOR CURRENT REPORTING PERIOD
				Q1	Q2	Q3	Q4				
11	Number of Kinerja Papua-supported linkages between CSOs, users, DPRD, Dinas, etc. at sub district and district levels which are active in oversight of service delivery	0	20	12	16	16	20	20 (100%)	20	20 (100%)	In Q4 FY14, four achievements were noted for Indicator 11. In Jayapura city, the P2TP2A team that was formed in Q3 FY14 has been actively meeting to discuss topics related to gender-based violence including forming and disseminating the SOP for Integrated Services (which aim to provide guidelines for officers/assistants in the Integrated Service Unit (UPT) to help service delivery officers provide better assistance to women and children who are victims of violence). Considering this linkage provided oversight of service delivery through their regular meetings this quarter, this has been documented as one achievement in Q4. In Jayawijaya as a result of the support and training that PKMK UGM has provided throughout the program, Kinerja Papua's three partner *puskesmas* in the district have revitalized their cross-sectoral meetings (*minilok eksternal/pertemuan lintas sektor)*. Puskesmas Hom-Hom, Hubikosi, and Musatfak have each conducted two *minilok eksternal* in March and August 2014 to discuss the action plans that each *puskesmas* formed. Head of districts and villages, as well as youth group members, attended these meetings along with *puskesmas* staff. These linkages have been documented as three achievements in Q4. Overall, Kinerja Papua has met 100% of its annual and program target of 20 linkages established or strengthened to provide active oversight of service delivery in the four partner districts. Total achievements recorded in this indicator include the MSFs formed at the DHO and puskesmas level, the P2TP2A team in Jayapura city, and the *minilok eksternal* activities that three partner *puskesmas* in Jayawijaya have revitalized through the support of PKMK UGM.
12	Number of Multi Stakeholder Forums (MSFs) established or strengthened by Kinerja Papua	0	16	16	16	16	16	16 (100%)	16	16 (100%)	No additional achievements were recorded in Q4 FY14 for Indicator 12. Overall, Kinerja Papua has met 100% of its annual and program target of 16 MSFs established or strengthened in the four districts. These MSFs were established in Q1 FY14 through the support of YHI, Yapeda, and Yukemdi (Kinerja Papua's MSF IOs based in Papua). During FY2014, the MSFs have played a key role in disseminating complaint surveys, forming service charters and technical recommendations, and monitoring the implementation of service charters by the *puskesmas* (see Indicators 13-15 for further details).

NO.	INDICATOR NAME	BASELINE	FY14 TARGET	FY14 ACHIEVEMENT				FY14 TO DATE	PROGRAM TARGET	PROGRAM TO DATE	REMARKS FOR CURRENT REPORTING PERIOD
				Q1	Q2	Q3	Q4				
13	Number of service charters produced with Kinerja Papua support in *puskesmas*	0	12	0	0	6	12	12 (100%)	12	12 (100%)	In Q4 FY14, six service charters were produced and signed in Jayawijaya and Mimika. The three service charters in Jayawijaya were signed by the Head of the MSF and the Head of partner *puskesmas,* while the three service charters in Mimika were signed by the Head of MSF, Head of partner *puskesmas,* as well as the Head of DHO, Head of the District, the Regent, and a representative of the Regional Planning and Development Agency (Bappeda). Overall, Kinerja Papua met 100% of its annual and program target of 12 service charters produced in *puskesmas.* Service charters were produced by the partner *puskesmas* in collaboration with MSFs as a response to the results of the complaint surveys. Action points that were beyond the scope of *puskesmas'* work were inserted into the technical recommendations (see Indicator 15).
14	Number of promises fulfilled by *puskesmas* addressing complaints about services received through a Kinerja Papua-supported complaint mechanism	0	60	0	0	0	123	123 (205%)	60	123 (205%)	In Q4 FY14, a total of 123 promises addressing complaints received through the complaint surveys (and documented in service charters) were fulfilled in Jayapura, Mimika, and Jayapura city. Health service delivery level MSFs monitored *puskesmas* promises by visiting and interviewing *puskesmas* staff. Monitoring activities in these three districts were conducted in August and September 2014. MSFs in Jayawijaya have not completed their monitoring activities. Achievements in that district will be documented when evidence is available. Overall, Kinerja Papua has met 205% of its annual and program target of 60 promises fulfilled by *puskesmas.* Examples of promises fulfilled include putting up signs prohibiting visitors to spit carelessly or bringing animals to the *puskesmas* and ensuring that *puskesmas* staff attends to patients based on queue numbers. Below is a breakdown of the number of promises fulfilled per district: • Jayapura : 58 out of 63 promises • Jayapura city : 20 out of 33 promises • Mimika : 45 out of 47 promises

NO.	INDICATOR NAME	BASELINE	FY14 TARGET	FY14 ACHIEVEMENT				FY14 TO DATE	PROGRAM TARGET	PROGRAM TO DATE	REMARKS FOR CURRENT REPORTING PERIOD
				Q1	Q2	Q3	Q4				
15	Number of Kinerja Papua supported recommendation to SKPD/DPRD/Bupati that have involved or are formally endorsed by other non-government actors	0	16	0	0	8	16	16 (100%)	16	16 (100%)	There are two types of technical recommendations targeted for the Kinerja Papua program. The first type of technical recommendation is dependent on the result of complaint surveys. The second type of technical recommendation is related to Minimum Service Standards (MSS) costing and integration into planning and budgeting documents. In Q4 FY14, eight technical recommendations were formed and signed. Six out of the eight technical recommendations address complaint survey results; these were formed and signed in Jayawijaya and Mimika. The three technical recommendations in Jayawijaya were signed by Head of the DHO, Head of the partner *puskesmas,* and Head of the *puskesmas* level MSF. The three technical recommendations in Mimika were signed by Head of the DHO, Head of the partner *puskesmas,* Head of the district level MSF, Head of the *puskesmas* level MSF, the Regent, and a representative from the Regional Planning and Development Agency (Bappeda) (three achievements). In addition, two technical recommendations related to MSS costing and integration were formed and signed in Jayapura and Mimika. In Jayapura, the technical recommendations were signed by the Head of the General and Program field (*Ketua Sub-bidang Umum dan Program)* and the Head of the district level MSF. In Mimika, the technical recommendations was signed by the Head of DHO, Head of partner *puskesmas,* and some non-partner *puskesmas* that were involved in the MSS Costing process as well as a representative from the Regional Planning and Development Agency (Bappeda). Overall, Kinerja Papua met 100% of its annual and program target of 16 recommendations. Achievements in this indicator include technical recommendations related to MSS Costing integration, technical recommendations addressing complaints received from the complaint surveys, and the establishment of a Regional Health System (*SKD*) in Mimika.

NO.	INDICATOR NAME	BASELINE	FY14 TARGET	FY14 ACHIEVEMENT				FY14 TO DATE	PROGRAM TARGET	PROGRAM TO DATE	REMARKS FOR CURRENT REPORTING PERIOD
				Q1	Q2	Q3	Q4				
16	Number of Kinerja Papua affiliated media-outlets that provide regular programing or dissemination activities related to health issues	0	28	15	26	32	34	34 (121%)	28	34 (121%)	In Q4 FY14, PPMN received a follow-on grant extending its contract with Kinerja Papua until the end of December 2014. During this quarter, MOUs were also signed between PPMN and two new local media organizations, namely Rock FM and Radio Suara Kasih Papua. Rock FM replaced RRI Jayapura who had been PPMN's local radio partner in Jayapura city for year 1 activities. Radio Suara Kasih Papua replaced Radio Kenambai Umbai who had been PPMN's local radio partner in Jayapura for year 1 activities. Overall, Kinerja Papua has met 121% of its annual and program target of 28 media outlets. The total 34 achievements recorded for this indicator include MOUs with 21 local media organizations (including radio stations, print media outlet, and TV stations), 12 *puskesmas* level MSFs involved in film screenings to the community, and 1 online website created by Forum Lenteng as the main outlet to collect and disseminate citizen journalist products (see Indicator 18 for more details regarding media products).
17	Number of Kinerja Papua-supported citizen journalists actively reporting on local government performance	0	40	20	37	36	28	70 (175%)	40	73 (183%)	In Q4 FY14, 28 citizen journalists (11 female, 39%) trained/mentored by PPMN and Forum Lenteng reported on local government performance and/or provided health information in the four Kinerja Papua districts. Of the 28 active citizen journalists in this quarter, 5 were new citizen journalists that did not write in previous quarters regarding Kinerja Papua issues. For FY14, Kinerja Papua met 175% of its annual target of 40 active citizen journalists reporting on government performance. A total of 70 active citizen journalists were trained/mentored by the Kinerja Papua program from October 2013 - September 2014 (see total against FY14 target). To assess "active citizen journalists" across the fiscal year (as opposed to during a quarter), the M&E team determines journalists that have been active at least once throughout the fiscal year. Journalists active in multiple quarters are not recorded twice against the annual target. Against the program target of 40 active citizen journalists, Kinerja Papua has met 183% of its target. A total of 73 citizen journalists are considered "active" using the same definition as above when assessing "active citizen journalists" across the fiscal year. The total of 73 comprises of 3 active citizen journalists in FY13 and 70 active citizen journalists in FY14.

NO.	INDICATOR NAME	BASELINE	FY14 TARGET	FY14 ACHIEVEMENT				FY14 TO DATE	PROGRAM TARGET	PROGRAM TO DATE	REMARKS FOR CURRENT REPORTING PERIOD
				Q1	Q2	Q3	Q4				
18	Number of media products produced by Kinerja Papua affiliated media-related entities on Kinerja Papua related issues	0	303	76	281	478	551	551 (182%)	313	563 (180%)	In Q4 FY14, 73 additional media products were produced by PPMN and Forum Lenteng. Of the 73 media products, 64 were articles and photo essays written by PPMN and Forum Lenteng's citizen journalists. The remaining 9 achievements were 3 Public Service Announcement (PSA) recordings formed by PPMN to be aired by the local radio stations, 4 talkshows aired in Rock FM and Radio Publik Mimika based in Jayapura city and Mimika respectively and 2 feature articles published by Cendrawasih Post, a daily local newspaper based in Jayapura city. Overall, Kinerja Papua has met 182% of its annual target of 303 media products and 180% of its program target of 313 media products. The total of 563 media products produced by Kinerja Papua affiliated media-related entities include talkshows and PSA recordings aired by local radio stations, health features created by local TV media outlet and print media outlet, and articles written by citizen journalists on topics related to Kinerja Papua such as local health governance and gender-based violence.
Replication Indicators											

NO.	INDICATOR NAME	BASELINE	FY14 TARGET	FY14 ACHIEVEMENT				FY14 TO DATE	PROGRAM TARGET	PROGRAM TO DATE	REMARKS FOR CURRENT REPORTING PERIOD
				Q1	Q2	Q3	Q4				
19	Number of times Kinerja Papua-supported practices for health management systems are institutionalized by *puskesmas* not receiving direct implementation support	0	12	0	3	13	27	27 (225%)	12	27 (225%)	In Q4 FY14, Kinerja Papua good practices were institutionalized 14 times by non-partner *puskesmas* within the four partner districts. A total of 13 non-partner *puskesmas* in Jayawijaya, Jayapura city, and Mimika formed their Proposed Plan of Work (RUK) for 2015 based on MSS Costing. Within the 13 non-partner *puskesmas*, nine were in Jayawijaya, three were in Jayapura city, and one was in Mimika. Kinerja Papua provided support through PKMK UGM's training on "Health Service Delivery Units' Planning" in Q3 FY14, where the formation of RUK was one of the topics of learning. In addition, one non-partner *puskesmas* (Puskesmas Kotaraja) in Jayapura city institutionalized Kinerja Papua health service delivery SOPs. The M&E team visited Puskesmas Kotaraja to verify the implementation of these SOPs along with the Kinerja Papua Health Specialist in July 2014. Documentation of this visit was used as evidence for this achievement. Overall, Kinerja Papua met 225% of its annual and program target of 12 Kinerja Papua supported practices being replicated in non-partner *puskesmas* within the four partner districts. Achievements for this indicator included replication of health service delivery SOPs and MSS Costing integration in Health Service Delivery Unit's planning.
20	Number of non Kinerja Papua-supported health service units where institutionalization of Kinerja-supported practices for health management takes place	0	12	0	3	10	15	15 (125%)	12	15 (125%)	In Q4 FY14, an additional five non-partner puskesmas in Mimika (one) and Jayapura city (four) replicated Kinerja Papua's supported practices (as detailed in Indicator 19). Overall, Kinerja Papua has met 125% of its annual and program target of 12 non-partner *puskesmas* adopting Kinerja Papua supported good practices. The 15 non-partner *puskesmas* are comprised of 10 non-partner *puskesmas* in Jayawijaya, four in Jayapura city, and one in Mimika.

NO.	INDICATOR NAME	BASELINE	FY14 TARGET	FY14 ACHIEVEMENT				FY14 TO DATE	PROGRAM TARGET	PROGRAM TO DATE	REMARKS FOR CURRENT REPORTING PERIOD
				Q1	Q2	Q3	Q4				
21	Number of Kinerja Papua-supported good practices which are formalized for replication/wider use by Indonesian civil society organizations	0	4	0	0	0	3	3 (75%)	4	3 (75%)	In Q4 FY14, three achievements were recorded for Indicator 21. PKMK UGM formed a video tutorial documenting five training topics that they covered throughout the project, including: • Complaint handling mechanisms • Technical guidance (*bimtek)* • Internal *puskesmas* staff meeting (*minilok internal)* • Cross-sectoral meetings (*minilok eksternal/pertemuan linsek)* • SOP (both DHO and *puskesmas* level) This video was shown by PKMK UGM during the Indonesia Public Health Policy Network (*Jaringan Kebijakan Kesehatan Indonesia – JKKI*) in Bandung in September 2014. The video has also been disseminated to PKMK UGM's training participants. There are additional plans to share this video with non-partner puskesmas to support sustainability and wider replication of Kinerja's good practices. In addition, BaKTi (a Kinerja grantee) has formed one videographic on the Regional Health System (*SKD*) and one video on SOPs regarding required/regulated services for pregnant women in *puskesmas*. The target audiences for these two videos are local communities and government staff in Papua. Thus far, the two videos have been shown during the Project Management Committee (PMC) meeting in Jayawijaya and shared during the Kinerja Papua IO Coordination meeting in September 2014. Overall, Kinerja Papua has met 75% of its annual and program target of 4 good practices which have been formalized for replication/wider use by Indonesian CSO. BaKTi is in the process of forming another four videos/videographics documenting the following Kinerja good practices: 1. MSS Costing Integration 2. Complaint mechanism (complaint surveys or complaint boxes) 3. MSF in health service unit levels 4. Integrated Services for Gender-Based Violence victims These four good practices are scheduled to be finalized and disseminated to a wider audience in Q1 FY15.
Program Goal											

NO.	INDICATOR NAME	BASELINE	FY14 TARGET	FY14 ACHIEVEMENT				FY14 TO DATE	PROGRAM TARGET	PROGRAM TO DATE	REMARKS FOR CURRENT REPORTING PERIOD
				Q1	Q2	Q3	Q4				
22	Customer satisfaction index related to health service units delivery	-	50%					n/a	50%	n/a	The baseline score was reported in the PMEP v. 4, together with the performance target. Kinerja Papua assumes that at least 50% of the units assessed by the CSS (customer satisfaction index) will improve their score during the Kinerja Papua program implementation period. If a unit increases its score, it means that client perception of services has improved. The final score will be reported at the end of the project, after end-line Customer Satisfaction Survey (CSS) is conducted in Q1 FY15. The total score possible for the CSS is 100.
	Puskesmas Tanjung Ria	73.47	n/a					-	n/a	-	
	Puskesmas Abe Pantai	72.30	n/a					-	n/a	-	
	Puskesmas Koya Barat	69.98	n/a					-	n/a	-	
	Puskesmas Sentani Kota	71.02	n/a					-	n/a	-	
	Puskesmas Dosai	71.66	n/a					-	n/a	-	
	Puskesmas Depapre	71.44	n/a					-	n/a	-	
	Puskesmas Homhom	68.81	n/a					-	n/a	-	
	Puskesmas Musatfak	70.17	n/a					-	n/a	-	
	Puskesmas Hubikosi	68.63	n/a					-	n/a	-	
	Puskesmas Mapuru Jaya	71.93	n/a					-	n/a	-	
	Puskesmas Limau Asri	68.85	n/a					-	n/a	-	
	Puskesmas Timika Kota	72.89	n/a					-	n/a	-	